

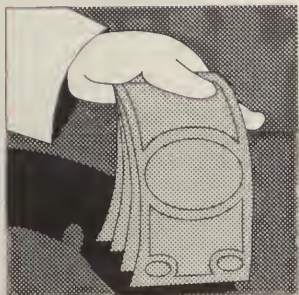
# Illinois Medicine

AMA interim  
meeting roundup... 8

January 17, 1992

ILLINOIS STATE MEDICAL SOCIETY

## Governor agrees to \$500 million loan to pay Medicaid providers if:



- The borrowing is short-term;
- Illinois General Assembly enacts cuts to bring spending in line with the state's lagging revenues;
- An established repayment plan is in place.

## 'No confidence' for PRO

by Kevin O'Brien

THE ILLINOIS STATE Medical Society Dec. 16 sent a letter to the U.S. Health Care Financing Administration saying that "serious problems" exist with the performance of the Crescent Counties Foundation for Medical Care. The letter

expressed "deep concern over the direction of the PRO program in Illinois."

CCFMC took over all direct PRO review on Sept. 30 when its downstate subcontractor, the Central Illinois Medical Review Organization, did not renew its contract with CCFMC.

The ISMS letter cited as a

key problem unsuccessful efforts to resolve a two-year dispute between CCFMC and the Chicago Medical Society regarding CMS representation on the PRO's board. On Nov. 16, the ISMS Board of Trustees authorized a letter of "no confidence" to HCFA if ongoing

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## Spending cuts, short-term loans proposed to erase Illinois deficit

CITING OVERDUE provider bills as justification, Gov. Jim Edgar called on the General Assembly to approve a \$500 million short-term borrowing plan during his emergency mid-year budget message Jan. 8.

The message was to be Edgar's second state-of-the-state address, but the state's worsening financial condition - punctuated by at least a \$350 million deficit - forced the governor to address only Illinois' immediate budgetary concerns.

In addition to the half-billion-dollar borrowing plan to reimburse Medicaid

providers, Edgar called for an annualized 3 percent across-the-board spending cut for the final five months of the fiscal year. The cuts will be squeezed into five months and have the effect of 7 percent slashes in appropriations for state agencies between February and July. Together, the spending cuts and borrowing plan will

put Illinois' budget back in balance and "in a better position to avoid huge backlogs of bills in the future," Edgar said.

"All of us regret that we have a budget gap after acting responsibly just six months ago," Edgar told the joint session of the legislature. "All of us regret that

(continued on page 10)

## Free clinic opens in Peoria

by Anna Brown



Heartland Community Clinic in Peoria opened its doors Dec. 10.

ON DEC. 10, 1991, a free clinic, supported entirely by the community, opened its doors to the medically indigent of Peoria and central Illinois. Heartland Community Clinic began receiving patients ineligible for public aid and with no health insurance, asking patients to pay only what they could afford - a donation of up to \$5.

"We've been very busy," said Alison Watkins, executive director and the only paid employee at the clinic. "Except for the executive director, the clinic is entirely staffed by volunteers. Heartland has been heavily supported by the community, including physicians, hospitals, businesses and religious organizations."

Heartland provides essential medical care for the more than 40,000 medically indigent and working poor in Peoria, Tazewell and Woodford counties. "This is a community-wide problem and we all have to work together to solve it," said David Gorenz, M.D., Heartland president and spokesman for the Peoria Medical Society.

"The idea for the clinic was originally backed by the Peoria Medical Society," said Watkins. "It was presented to area physicians, who were

very positive and interested in supporting the project. A task force was developed, and the hospitals were approached, and agreed to participate."

"Probably the most difficult part for the task force was determining if there was a need," said Dr. Gorenz. "Physicians knew that a lot of patients were falling through the cracks, but we didn't know just how to document this. What we did find was that it was not completely true that people were being denied health care. They would usually go to the emergency room after their conditions had become severe."

### Community support

"We support this clinic enthusiastically because, to us, it is a win-win situation," said Wayne Zimmerman, vice president of human services at the Peoria-based Caterpillar Inc. "Those who are presently underserved from a health services standpoint

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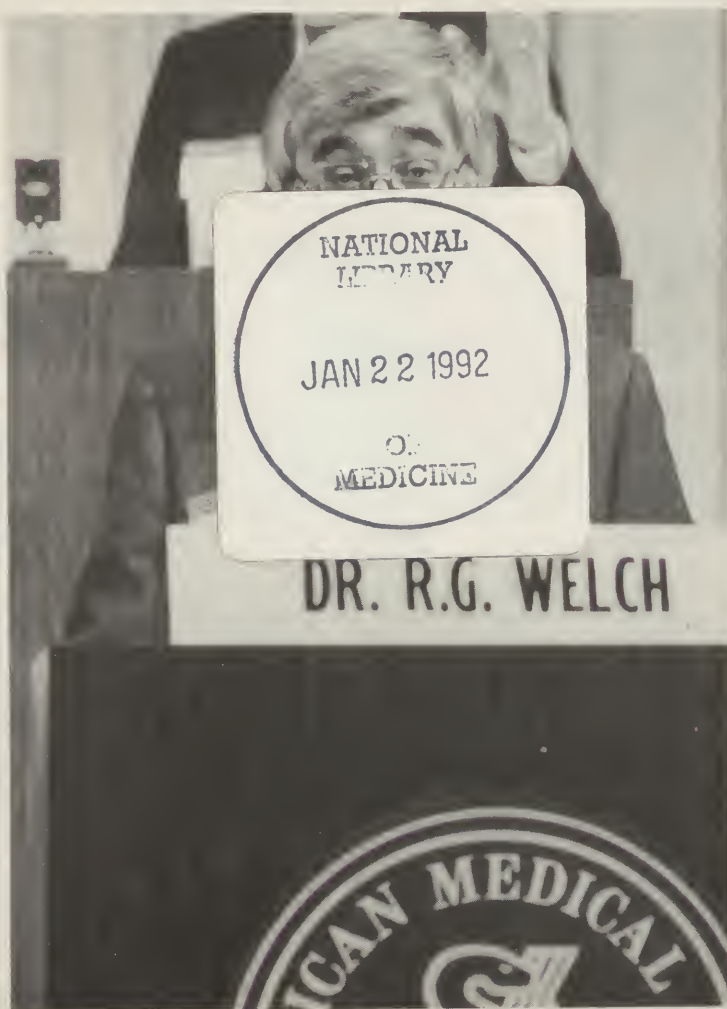
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Tenth District Trustee Ronald G. Welch, M.D., chairs Reference Committee A at the AMA's interim meeting in Las Vegas. His efforts were commended by the House of Delegates. See story, page 8. ▲

Photo courtesy of the American Medical Association

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Outpatient hospital prices up 20 percent

Outpatient charges for common hospital procedures rose an average of 20 percent in 1990 in Illinois, with some charges jumping as much as 26 percent, according to the Illinois Health Care Cost Containment Council. At the same time prices were rising, outpatient revenues went up about 23 percent on average, the council said in its annual "Report of Selected Prices at Illinois Hospitals."

Procedures that showed the highest increases are tonsillectomy with adenoidectomy, up 26 percent; GI endoscopy, up 24 percent; D & C, up 23 percent; and cystoscopy, up 21 percent. Some procedures increased only slightly, including mammograms (1 percent), HIV Western Blot (3 percent) and brain MRIs (6 percent).

Prices for inpatient services also rose sharply in 1990, with operating room services increasing 17 percent, electrocardiograms going up 13 percent, blood sugar tests rising 12 percent and upper GI series jumping 10 percent.

Council Executive Director John Noak explained that some of the "wide swings" in hospital charges might be attributed to the fact that the council does not adjust the figures it receives from hospitals to account for the severity of a patient's illness.

Noak also warned that many council figures do not include charges "for all the care that a patient receives during a hospital stay. For example, fees for professional services

provided by physicians, surgeons and other medical specialists are generally not contained in our data."

Because of this, Noak suggests the report serve as a basic resource for patients to discuss hospital prices and quality of care issues with their physicians.

Chicago hires health care administrator

Chicago Commissioner of Health Sister Sheila Lyne, R.S.M., has appointed William F. Card, a health care administrator, director of the Chicago Department of Health's Bureau of Community Health. As director of the city's largest health bureau, Card will administer a \$30 million annual budget, 950 employees and 18 clinics.

During 1990, the bureau provided health services to more than 300,000 Chicago residents, mainly through its maternal-child, adult and comprehensive clinics. CDOH estimates that 25 percent of all pregnant women in Chicago receive care at one of the city's clinics.

"We are quite proud to have a manager of Mr. Card's caliber in charge of such an important operation," Sister Sheila said. "In these times of limited resources, it is especially important to have stronger and better management. We are attracting that kind of top-shelf management to the Health Department."

Previously, Card served as an associate director of the Joint Commission on Accreditation of Healthcare Organizations, working with physician and administrative accreditation surveyors. ▲

CPT grace period running out

Medicare to monitor MD use of codes

by Tamara Strom

ONLY TWO WEEKS remain in the grace period allowing physicians to complete Medicare claims with the old 1991 evaluation and management codes.

While Medicare will pay claims with the old codes for services provided through January 1992, physicians will be reimbursed at 1991 rates, which could be lower. Doctors have until March 31 to submit claims for evaluation and management services provided through January billed under the old coding system.

Beginning Feb. 1, doctors providing care considered to be evaluation and management in nature must bill for services rendered to Medicare patients using only the new evaluation and management codes. Failure to use the new codes will result in a claim denial, according to the U.S. Health Care Financing Administration, the government agency that oversees Medicare.

To help monitor physician proficiency with the new codes, Blue Cross and Blue Shield of Illinois, the state's Medicare Part B carrier, will begin an educational code evaluation program in February. Every week, the Blues will randomly select 25 claims from Illinois physicians (one per physician) to evaluate the code selected to report this level of care for reimbursement. Physicians may be asked to document the case and their reasons for using the specific code billed.

The program is educational only, with no financial penalties or recoupments expected if physicians are identified as having submitted an incorrect visit code. (For additional information on selecting correct codes, see sidebar above.)

To be safe, however, physicians should not attempt to "cross-walk" between the old codes and the new codes. The new codes are defined differently and physicians are advised to study them carefully and select appropriate office visit codes by evaluating the level of history, examination and medical decision making required in each case.

Can change specialty designation

Illinois physicians also can expect a letter soon from Blue Cross, the Medicare Part B carrier, asking them to declare their specialties for Medicare billing purposes. Doctors have until March 1 to revise their Medicare specialty designations. The Blue Cross monitoring program will rely on these specialty declarations to profile physicians and their coding performance.

In addition, because of the com-

Common questions on new CPT codes

Following is one of the most often asked physician questions about implementation of the new CPT evaluation and management codes. Additional questions will appear in future issues of *Illinois Medicine*.

**Q:** Can the new evaluation and management codes be interchanged with the old codes? For example, is a 90020 now a 99205 or is a 90040 now a 99212?

**A:** No. Translating old codes into new codes is called "cross-walking." The new coding system is more complicated and represents a revised method of classifying physician services. Selecting the proper code depends on the history, examination and the type of clinical decision making a doctor uses in providing the service in conjunction with several other factors.

To obtain a copy of *CPT 1992*, write the American Medical Association Order Department, % 0P0-54192, P.O. Box 10950, Chicago, Ill. 60610. AMA-member cost is \$27. ▲

plex formula used to determine the new Medicare fees for physician services, doctors do not have enough information to calculate their own payment rates. The final reimbursement paid by Blue Cross is in part determined by the "historical payment" for the area in which the doctor practices. Physicians cannot accurately calculate their reimbursement rates without this historical figure.

Blue Cross, the Medicare Part B carrier, has the figures and used them in calculating the 1992 Medicare fees. These fees were reported on the disclosure report physicians recently received.

Physicians also should be aware that a new HCFA directive prohibits reimbursing doctors for administering an injection when it is billed in conjunction with an office visit. Effective Jan. 1, physicians will be reimbursed for administering an injection only if it is scheduled and billed separately. Physicians will continue to be reimbursed the average wholesale price for the drug itself.

Physicians with questions about the new coding system can call the Illinois State Medical Society Division of Health Care Finance at (800) 782-ISMS. ▲

Corrections and Clarifications

An article in the Dec. 20 issue incorrectly listed one of the four coverage options offered by the Illinois State Medical Inter-Insurance Exchange. The correct options are: \$2 million/\$4 million; \$1 million/\$3 million; \$500,000/\$1.5 million; and \$250,000/\$750,000. The first figure refers to the maximum the Exchange will pay for a settlement or award arising from a single claim; the second is the maximum it will pay for all claims in a given year. ▲

Physician Facts

Percent of U.S. physicians whose practices advertised, 1982-1987

All	18.7%
Male	18.0%
Female	29.2%
Board certified	17.5%
Uncertified	21.9%
Plastic surgery	33.3%
Family practice	27.1%
Internal medicine	19.4%
Pediatrics	17.5%
General surgery	16.1%
Ob/Gyn	16.0%
Psychiatry	12.5%

Source: American Medical Association Socioeconomic Monitoring System. Includes print and electronic advertising.

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# Illinois budget woes echo national economic trends

## News Analysis

CITING national economic trends, Illinois Gov. Jim Edgar blames the recession for Illinois' worsening budget woes.

Woefully slow revenues combined with increased spending pressures are putting the state's fiscal 1992 budget about \$520 million in the hole, Edgar said in December. The governor's staff said later this figure probably could be "managed" down to a \$350 million year-end deficit.

Overdue medical payments for public aid providers are not being paid due to the cash shortfall, while increased costs for the state employees' health insurance plan and a rise in home health care services are cited as contributing to the deficit.

To offset the shortfall, Edgar proposed a 3 percent across-the-board cut in 1992 appropriations for all state departments funded by general revenue funds. Because the soonest such spending cuts could be enacted would be around Feb. 1, the 3 percent cut would have the impact of a 7 percent cut over the last five months of the fiscal year, according to the Bureau of the Budget. If the General Assembly does not agree to these cuts quickly, or drags its feet coming up with a solution of its own, the real effect will get worse as time goes on, warned Edgar's Budget Director Joan Walters.

"We've directed [state departments] to look at two things," Walters said Dec. 30 during public hearings in Chicago on the budget. "First we asked how a 3 percent across-the-board cut would affect the agency. Then [we asked them to look at] how alternative approaches to achieving a 3 percent cut would be accomplished."

Walters stressed at the hearing that Edgar remains committed to his promise to not raise taxes. In presenting his first budget as governor last March, Edgar rejected long-term borrowing as fiscally irresponsible. Walters said, however, that the governor might consider borrowing to pay the backlog of medical provider bills — provided a plan is in place to repay the money, the legislature agrees to bring spending in line with revenues and the borrowing is short-term only.

### Human services cuts protested

Some legislators and special interest groups such as senior citizens are pressing the governor to come up with alternatives to cutting human services programs. Although most human services programs did not suffer severe cuts, some programs, such as the Aid to the Medically Indigent and "optional" health services, were eliminated.

A cornerstone of the mid-July budget agreement was a provision to pay overdue provider bills and bring the payment cycle down to 60 days by the end of the fiscal year. If revenues had reached planned levels, budget officials said, the payment cycle would now be halfway between 83 and the targeted 60 days. Instead, the average payment cycle now stands at about 113 days, with some providers waiting longer for Medi-

caid reimbursements. "It depends on who you are and what day it is," budget officials said about how long it takes a provider to be reimbursed.

As of Jan. 2, the state treasury reported only \$1.5 million on hand and \$486.5 million in bills. About \$89 million of that total is Medicaid bills. An additional \$469.7 million in processed Medicaid provider bills are sitting in boxes at the Department of Public Aid waiting for the comptroller's office to say there is enough money in the Illinois checking account to pay them.

At the comptroller's request, "Pub-

lic Aid has not delivered a significant amount of bills since Dec. 16," said Sen. Penny Severns (D-Decatur), vice chairman of the Senate Appropriations I Committee. "I know first-hand providers who have not been able to meet payroll. The medical providers have acted in good faith. I don't think many are in a position to wait much longer."

"The comptroller has not paid a lot of bills because of limited cash flow," Walters responded. "Until now the amount was limited because of space [for the claims] at the comptroller's offices."

### Long-term solutions

Several legislators called for the governor to begin seeking long-term solutions for some of the state's most pressing issues, among them rising health care costs and the increased need for state-paid health services.

"Health care is a tremendously important, long-range issue," Walters told the legislators. "We're looking at a variety of solutions, not only for the \$4 billion spent on Medicaid but for insurance for state employees and the uninsured in this state." She

(continued on page 10)

## Blue Cross Blue Shield



# REPORT

## FOR *Illinois Physicians*

### INTRODUCING PROVIDER/SUBMITTER CLAIM STATUS (PSCS):

#### A NEW SERVICE FROM BCBSI TO MEET YOUR NEEDS FOR CLAIM STATUS INFORMATION FASTER AND MORE EFFICIENTLY

Starting this month, Blue Cross and Blue Shield of Illinois (BCBSI) will offer a new claim status information service -- **Provider/Submitter Claim Status (PSCS)** -- to providers with access to a BCBSI terminal or terminal emulator.

With PSCS, you'll be able to follow the status of your electronically submitted Blue Cross Blue Shield claims from submission to remittance faster and more efficiently than ever before.

### Getting Started With PSCS

Simply sign on to your BCBSI terminal or terminal emulator in the normal manner and enter "PSCS" to access this new claim status information service from BCBSI. Next, enter your provider number and choose the type of claims--Submitted, In Process, or Finalized--you would like to view. To view the status of a specific Submitted, In Process, or Finalized Claim, enter the first few letters of the patient's last name as directed. To view a specific claim's remittance information, enter Finalized Claims and the patient's line number as directed.

As an added service, all electronically submitted Blue Cross Blue Shield claims will be available for viewing with PSCS for 45 days after they have been received at BCBSI.

To learn more about PSCS and how it can work for you, please contact the Provider Assistance Unit at (312) 938-7340.

### 1992 CPT Codes

Effective January 1, 1992, Blue Cross and Blue Shield of Illinois (BCBSI) will accept both the 1992 and 1991 Current Procedural Terminology (CPT) codes. The 1992 edition of Current Procedural Terminology is available now from the American Medical Association (AMA) for \$27. To obtain a copy, call the AMA at (800) 621-8335.

(This report is a service to the physicians of Illinois.)

(1/17/92)



## Editorial

## Six and a half really good reasons to blow up the Data Bank

**T**he National Practitioner Data Bank came in for some heavy flak during the recent AMA interim meeting. Unlike wine, cheese and teenagers, the Data Bank does not improve with age. Annual resolutions directing the AMA to influence and control the Data Bank have, over the last two years, turned into impassioned pleas to dismantle it. This year's protest had strong support from several members of the Illinois Delegation. Here's six (and a half) reasons why they're right.

**1. The only people who support the Data Bank are the people employed by the subcontractor who runs it.** The Data Bank seems to be universally loathed by almost everyone else. Doctors hate it. Hospitals hate it. Insurance companies hate it. Congress probably doesn't hate it, yet, but they will. See No. 2.

**2. The program is way over budget and looks to continue that way.** The program's cost is scandalous. Originally projected to be self-supporting at \$2 per hospital inquiry, the Data Bank tripled its fee to hospitals within the first year of operation, to \$6.

**3. The Data Bank has never yet met a deadline it couldn't miss, and**

**4. Its results are riddled with errors.** The program's execution is close to criminal. Files are routinely lost, errors in data input abound and the turnaround time has stretched far beyond the promised deadlines. The bureaucratic swamp that engulfs almost any government project has found its primeval source in the Data Bank. Summed up, it's a fatally flawed concept executed at a level of efficiency that makes the Post Office look good.

**5. It could get a whole lot worse.** You ain't seen nuthin' yet. The Data Bank is now considering reporting not only malpractice settlements and awards, but also open claims. Information in open claims is highly confidential; it is imperative that it be protected, to assure the privacy of patients and physicians alike. And our legal system is such that anyone can sue anyone else for anything, no matter how frivolous. The concept of "innocent until proven guilty" is compromised by the idea of reporting open malpractice claims.

**5, continued. It gets worse.** Now that the Data Bank is "up and running," you should pardon the expression, some special interest groups are pushing for access to the information it contains, however inaccurate it might be. Chief among these groups are the Ralph Nader-like public action groups that think it would be swell if members of the public could access the data.

The other group that would like – desperately – to get their hands on the data is our old friends, the plaintiffs' bar. These attorneys claim the information in the Data Bank is vital to building their cases and compensating their injured patients.

**6. It's not necessary.** In addition to being hideously inefficient, the Data Bank is entirely duplicative of the efforts of state medical licensing and disciplinary boards. These agencies already do what the enabling legislation intended the Data Bank to do: prevent physicians with records of negligence or criminal activity from obtaining new licenses and new jobs in other states without revealing their pasts.

So the biggest question about the Data Bank is not What? or Where? or even, for the masochistic among us, How? It's Why? Why bother? Why put ourselves and our hospitals through this? Why not let the state boards do their job?

Why not get rid of the Data Bank? ▲



"He says it was a miracle that he recovered, so he sent his insurance forms to the church."

## President's Column

## A word to the wise from Dr. Koop



Robert M. Reardon, M.D.

"I am a Brooklyn boy ... I'm proud to have my roots in Brooklyn." This is as true of me as it is of the doctor who said it first – former Surgeon General C. Everett Koop, M.D. Dr. Koop's new autobiography, *The Nation's Family Doctor*, was a much treasured Christmas gift from my son.

Dr. Koop was appointed by and served two terms under President Reagan. When he was installed as Surgeon General, Dr. Koop had an announced agenda that included a strong anti-tobacco stand. Fate, in the form of the deadly disease AIDS, intervened, and Dr. Koop gained international fame as the doctor who dared to talk – on television – about sex and condoms.

Now a regular on the talk show and lecture circuit, Dr. Koop continues to address the issue of AIDS and has expanded his focus to the entire health care arena in this country.

"In 1991, health care cost the U.S. \$671 billion – more than education and defense together." In spite of this overwhelming cost, an estimated 34 million Americans lack health insurance and so have no access to routine health care.

When asked how to approach this problem, the outspoken Dr. Koop doesn't hesitate. The first item on his agenda for change, he says, would be tort reform.

"Change the tort system for malpractice claims," he recommends. "Skip the courts and go to mandatory binding arbitration." The overburdened courts and our confrontational legal system hurt, not help, those who have been truly harmed.

A system of arbitration rather than trial would reduce costs and the amount of defensive medicine doctors are forced to practice.

"The health of the nation would not suffer if we reduced by 30 percent the diagnostic and therapeutic procedures we use today," he says.

Dr. Koop also thinks that this country's high-tech climate drives medical costs; every time a hospital adds a new technology or new diagnostic capability, costs go up.

Never afraid to take a controversial

stand, Dr. Koop has one recommendation that will certainly raise some eyebrows. He suggests that medical education should be subsidized by the government.

"We're the only civilized nation in the world, with the possible exception of South Africa, that doesn't do this," he says. "And it's the only way you can get a handle on manpower. We have too many high-priced specialists in the suburbs and not enough doctors in rural America or the city ghettos."

Dr. Koop also recommends that the health insurance industry go "back to basics."

"Insurance companies go out into the community and (select out) those people who are high risk and who would cost them money. They end up just insuring the healthy. That's unfair and unconscionable."

And it helps drive up costs. Those high-risk or chronically ill people who can't get health insurance coverage end up getting help paid for by our taxes or by cost shifting by providers and insurance companies.

The administrative costs of the health insurance industry help drive up costs, too, Dr. Koop says.

"Blue Cross and Blue Shield of Massachusetts employs more paper pushers than does the entire country of Canada," he claims.

While we may not agree with everything Dr. Koop has to say, most physicians would agree that his efforts to educate the public about the problems in health care are meritorious. The important thing is that we all work together for a solid, long-term gain: access to health care for all Americans. ▲

Robert M. Reardon, M.D.  
President

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## Guest Editorial

# Attention, Doctor – you should be a political activist



by Biswamay Ray, M.D.

Physicians are supposed to devote their time to patient care. Who would have thought the day would come when we would have to be political activists? But that's precisely what has happened.

I recently attended a two-day political education seminar in Washington, D.C. It left no doubt in my mind that unless physicians become politically active, we will be overwhelmed by a sea of change, mostly unfavorable to us.

The seminar focused on several issues: RBRVS, mandatory HIV testing for health care workers, health care reform and the need for political activism, among others.

On the topic of RBRVS, physicians have done a tremendous job, launching a massive congressional letter writing campaign. While we have seen some favorable changes in the law as a result, much more needs to be done.

But getting Congress' support on the question of mandatory HIV testing is another matter. Except for the incident involving the Florida dentist, there has been no proven HIV transmission from health care worker to patient. We must ask Congress to weigh the available scientific evidence against the hysteria that is sweeping the country. Based on personal experience, it will not be easy to convince them. Political pressure, rather than scientific evidence, will carry the day.

Other reasons for political activism are the 1992 elections and, more importantly, health care reform.

The coming elections are going to be very important for physicians. It seems that neither the Republicans nor the Democrats have been "physician-friendly" lately. President Bush, architect of brilliant foreign policies, is far ahead in his efforts for the 270 electoral votes needed to win re-election. Of course, Ron Brown, the chairman of the Democratic National Committee, has a different viewpoint. He says the Democrats *do* have a chance to win the White House in 1992. Polls may be misinterpreted, and the economy is in trouble, which could affect the election.

Political analysts remind us, "Politicians come and go, but the party stays. If you want to get involved, you should ask. Don't wait, join a party and start working."

The recent Pennsylvania senatorial election made it clear that health care issues are going to be very important in 1992. Polls show that voters are increasingly negative about the current system, that a growing dissatisfaction with access to care exists, and health care costs are the second most important concern of the public (after drugs). People believe that physicians do more procedures to cover malpractice costs, and that physicians and hospitals are responsible for rising health care costs.

The polls also show that 40 percent want complete rebuilding of the system, 50 percent want fundamental changes, and 65 percent are dissatisfied with health care costs. But more surprising is the finding that Americans see no conflict between cutting costs and quality of care. There is a strong demand for reform but no plan for reducing costs.

No one questions the need for health care reform. The challenge is to find ways for universal access to affordable health care without sacrificing freedom of choice and quality of care.

The plight of 34 million Americans with no health insurance, and the many more Americans with inadequate health insurance, can no longer be ignored.

The Republican Party's position is that incentives to reduce costs are preferable to governmental mandates. The key elements of health care reform would be tax reform, tort reform, preventive medicine and reduction of Medicare and Medicaid administrative costs.

Are the golden days of medicine already behind us? Has the face of medicine changed forever? Where does the onslaught of federal and state legislation, the restricting rules and regulations, the ever-increasing governmental intrusion end? What is crystal clear is that changes in the health care system are inevitable, whether we like it or not. No longer can physicians ignore the ever-tightening social, political and economic grip on medicine.

Aren't we the spokesmen for our patients? Aren't we the caretakers of this nation's health? Physicians can no longer be apathetic bystanders. We must take an active role in the ongoing health care reform debate. We must lead the nation with innovative ideas to correct the flaws and improve on the existing health care system so that it is more accessible, affordable, and at the same time preserves quality of care.

But can we successfully do this without a determined proactive stand and without working closely with the politicians who, after all, decide who gets what, and when? Don't give up. Stand up for your rights and your patients' rights. So what if the odds are great? ▲

*Dr. Ray, a urologist from Oak Brook, is a Third District trustee.*



"Perhaps you'd like to tidy up a bit before the TV people arrive."

## YOCON<sup>®</sup> YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

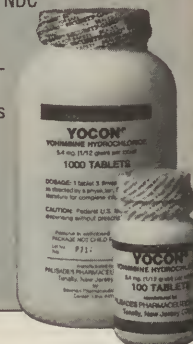
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# Exchange risk management program promotes communication, documentation

by Anna Brown

PREVENTING LITIGATION is the primary goal of the Illinois State Medical Inter-Insurance Exchange risk management department. Addressing conditions that encourage litigation is important, particularly if inter-office or patient communication is the problem. The Exchange provides a three-step risk management program designed to work with physicians to improve communication and documentation in both the office and the hospital.

"In the last few years, the threat of malpractice litigation has become an

inescapable reality for everyone in medicine," said Harold L. Jensen, M.D., chairman of the Exchange Board of Governors in the Exchange's self-study risk management handbook. "There are things we can do about it. One of the most fundamental is effective risk management."

Exchange policyholders may be recommended to risk management training when a suit has been closed with indemnity. One of the Exchange Physician Review and Evaluation Panels (PREP) will review the case after it is closed and may decide that risk management training is ap-

propriate, recommending one or more of three levels of training.

"The levels of risk management we have created are not progressive. That is, one level is not 'worse' than another," says Jere E. Freidheim, M.D., chairman of the Exchange Risk Management Committee. "A physician may be referred to any of the three levels, and you can be ostensibly involved in all three."

## Level I - Self-study program

Level I is the self-study program that new ISMIE policyholders complete when they join the Exchange. The program includes a handbook,

"Managing Your Risk in the Office/at the Hospital," and a videotape. Both stress effective communication techniques between the physician, office staff and the patient, and include the importance of the attitudes of all parties involved.

The manual also explores documentation, confidentiality, billing and collection, and patient selection. Successfully completing the test accompanying the self-study program entitles the participant to six hours of American Medical Association/Physician Recognition Award Category I credit.

## Level II - Seminars

"About 70 to 80 physicians a year are required to attend Exchange risk management seminars," says Dr. Freidheim. The seminars focus on communication and documentation, although other topics are also presented, he says.

In 1991, the Exchange held nine PREP-mandated seminars. Each three-hour seminar is presented by two physicians and an Exchange defense attorney. The physicians focus on such issues as effective physician-patient communication, incident and complaint handling, and general risk reduction. Documentation is also described in detail. The attorney's program, "Assisting in Your Own Defense," features further discussion of the physician-patient relationship, and describes how physician defendants can help to research their own claims and serve as medical experts to their attorneys.

A PREP-mandated seminar open to all physicians will be held March 1 during the Chicago Medical Society's Midwest Clinical Conference, from 8 a.m. to noon at the Fairmont Hotel in Chicago. Physicians attending this and the other PREP-mandated seminars receive three hours of AMA/PRA Category I credit. Interested physicians should contact CMS for registration information for the March 1 program or the Exchange risk management department for the other programs.

## Level III - Office assessment

A recent addition to Exchange risk management training is the office assessment program. If PREP recommends a policyholder for office assessment, the physician is first asked to complete a self-assessment questionnaire. Based on the results, risk management staff create a practice profile, and an on-site assessment is conducted by a member of the Risk Management Committee who has comparable practice experience, and an Exchange staff member.

The assessment includes a tour of the office, interviews with the physician and selected office staff and a review of randomly selected charts. The physician surveyor and risk management staff then present final reports to the Risk Management Committee.

"We have made about ten office visits since April of 1990," says Dr. Freidheim. "In most cases, physicians have been very helpful and are interested in improving the problem. We have hopes that this will help."▲

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## Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

**Q:** What is the easiest way to correct a National Practitioner Data Bank Medical Malpractice Payment Report?

**A:** If you discover a discrepancy in a report about your policy payment, contact by phone, fax or letter the Illinois State Medical Inter-Insurance Exchange Policyholder Relations Division or the professional liability analyst who handled your case. The analyst will review your request for a change according to Data Bank

guidelines and let you know if the requested change can be made. Although the Exchange makes every effort to ensure that reports are agreeable to the policyholder, the Exchange is legally bound to follow the guidelines.

**Q:** How does a physician qualify for the Newly Practicing Physician Discount?

**A:** The discount is applicable for any physician who, as of the incep-

tion date of insurance with the Exchange, is beginning the practice of medicine or has been in practice for less than 36 months following:

1. Attainment of a medical license;
2. Completion of residency or fellowship training, including completion of training in a different medical specialty by an established physician; or
3. Completion of military service or other extended government service.

**Q:** If I have a claim closed with an indemnity payment, how does it affect my insurance?

**A:** Claims closed with indemnity payments are reviewed by the Physician Review and Evaluation Panels

(PREP), a committee composed of Exchange policyholders. The committee's responsibility is to help the Exchange accurately and fairly evaluate exposure to malpractice risk.

While a single case may initiate a review, the PREP committees study the policyholder's entire underwriting profile, including practice location, practice relationships and previous claim/suit experience, when determining what action to take. The committees may take no action; may require the policyholder to undertake specific risk management procedures; may assess a premium surcharge; may restrict the policyholder's coverage; or may institute any combination of the foregoing. The committees may also recommend non-renewal of the policy. ▲

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(ranitidine hydrochloride)  
antac<sup>®</sup> 300 Tablets  
(ranitidine hydrochloride)  
antac<sup>®</sup> Syrup  
(ranitidine hydrochloride)

CONDENSED  
BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac<sup>®</sup> product labeling.

**INDICATIONS AND USAGE:** Zantac<sup>®</sup> is indicated in:  
• Short-term treatment of active duodenal ulcer. Most patients heal within 4 weeks.

• Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers.

• The treatment of pathological hypersecretory conditions (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).

• Short-term treatment of active, benign gastric ulcer. Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.

• Treatment of gastroesophageal reflux disease (GERD). Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy and is maintained throughout a 6-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** Zantac<sup>®</sup> is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS: General:** 1. Symptomatic response to Zantac<sup>®</sup> therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION).

Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

**Laboratory Tests:** False-positive tests for urine protein with sulfosalicylic acid may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

**Drug Interactions:** Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

**Pregnancy: Teratogenic Effects: Pregnancy Category B:** Reproduction studies have been performed in rats and rabbits at doses up to 150 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** Headache, sometimes severe, seems to be related to Zantac<sup>®</sup> administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg i.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocellular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia, anaphylaxis, angioneurotic edema, and small increases in serum creatinine).

**OVERDOSAGE:** Information concerning possible overdosage and its treatment appears in the full prescribing information.

**DOSAGE AND ADMINISTRATION:** (See complete prescribing information in Zantac<sup>®</sup> product labeling.)

**Dosage Adjustment for Patients with Impaired Renal Function:** On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoons) equivalent to 150 mg of ranitidine every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

**HOW SUPPLIED:** Zantac<sup>®</sup> 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac<sup>®</sup> 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-87) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac<sup>®</sup> Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in light, light-resistant containers as defined in the USP/NF.

September 1991

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# Illinois helps convince AMA on Data Bank, HIV testing

by Kevin O'Brien

AT THE AMERICAN Medical Association interim meeting, Illinois physicians again demonstrated they're often ahead of the curve where issues of national importance to physicians are concerned. In Las Vegas, the issues were dismantling the National Practitioner Data Bank and testing patients for HIV.

Last April, the Illinois State Medical Society House of Delegates, after defeating an ISMS reference committee recommendation to go slow, directed the AMA to "develop a strategy that will lead to the timely and systematic dismantling of the Data Bank."

After considerable debate at its December meeting, the AMA House of Delegates came to the same conclusion. The AMA reference committee recommended caution, offering a substitute resolution mandating further statistical study of the Data Bank's shortcomings. Instead, the House adopted a short and succinct Texas-sponsored resolution: "Resolved, That the American Medical Association seek to abolish the National Practitioner Data Bank."

One of the staunchest advocates of dismantling the Data Bank has been Illinois delegate Chester C. Danehower Jr., M.D., of Peoria. Noting that action on the issue stalled at the AMA's annual meeting in Chicago

last June despite a "ground swell that was occurring then to get rid of it," Dr. Danehower told *Illinois Medicine* he thinks the delegates "just decided that they had had enough of it."

Dr. Danehower also discounted arguments that efforts to dismantle the Data Bank are futile. "They told me I had a pipe dream, if I really thought we could get rid of the Data Bank," he said. "Well, as soon as you take that position, that it can't be done, you cannot get rid of something. You have to get try to get rid of things

## Morgan Meyer honored for AMA service



*In a special ceremony, the Illinois delegation honored Morgan M. Meyer, M.D., of Lombard, for his 20 years of service as an Illinois delegate to the AMA. Dr. Meyer did not stand for re-election to the delegation. ▲*

that are wrong. And this is wrong.

"The AMA needs to admit that they made a mistake [when it agreed to the Data Bank's establishment], and then they need to correct the mistake. Learn from the error that was made."

## HIV testing policy conforms to Illinois law

The delegates also adopted a resolution permitting physicians to test for HIV "without explicit informed consent," and, as indicated by their medical judgment, "to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection." The resolution also directed the AMA to develop model state and federal legislation to accomplish the same objective. The policy has been part of Illinois law since 1988.

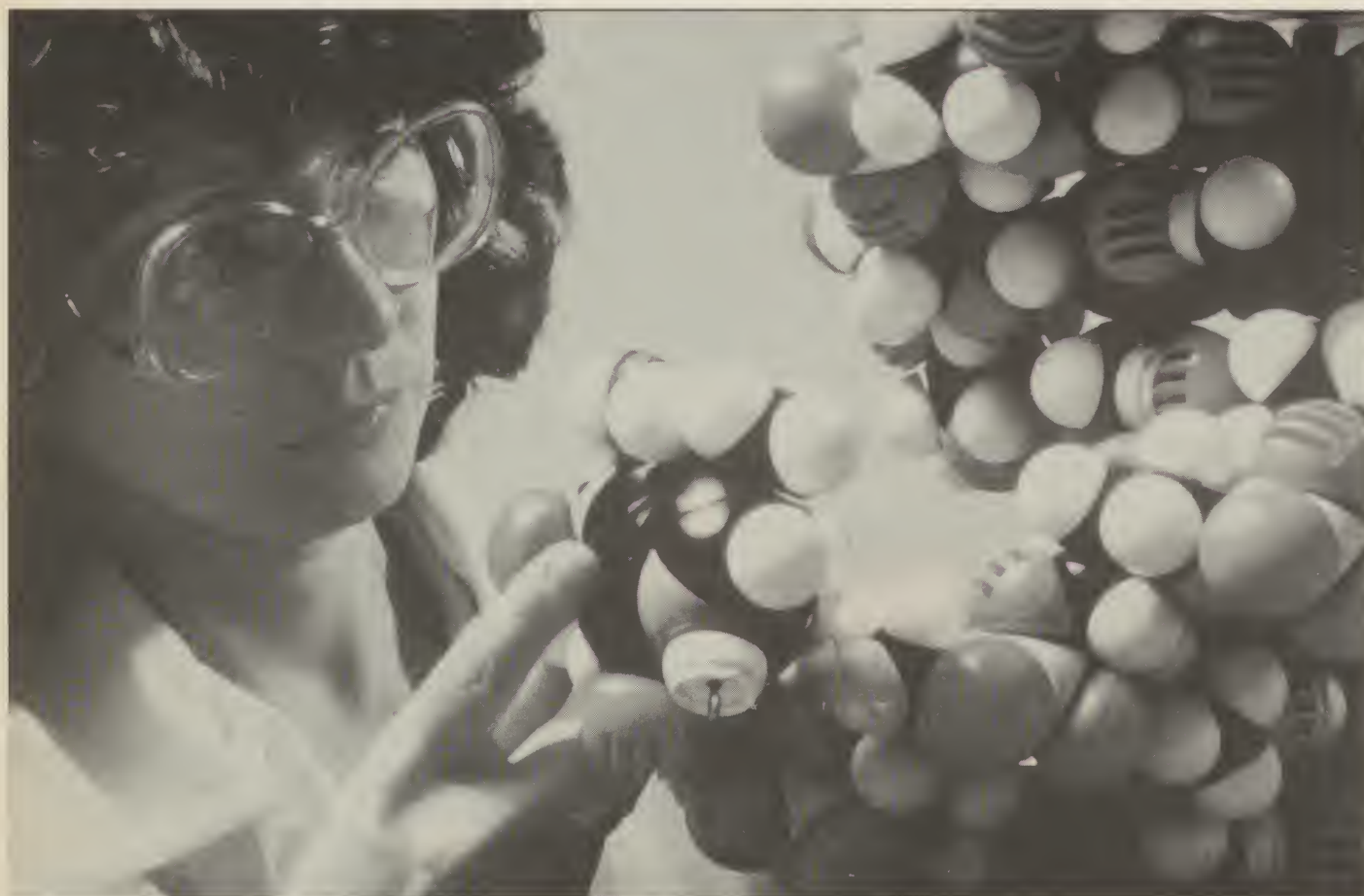
"Illinois physicians have long believed that HIV testing should be based on medical, rather than political, considerations," said ISMS President Robert M. Reardon, M.D. "The action of the AMA House of Delegates confirms Illinois' judgment, by bringing AMA policy into conformity with Illinois law."

One year after its enactment, the Illinois AIDS Confidentiality Act of 1987 was amended to exempt physicians from obtaining specific written consent to test for HIV when the physician concludes the test is medically indicated and the patient has otherwise consented to treatment. Illinois physicians were still ethically bound to gain a patient's informed consent, albeit not written, for any diagnosis and treatment, and to guard patient confidentiality scrupulously.

## Other House actions

In other action, the delegates deleted a provision from an American College of Physicians-sponsored resolution directing the AMA to work to repeal provisions of the Illinois Criminal Code ensuring anonymity of individuals participating in state executions. Calling the resolution unnecessary, Dr. Reardon said before the meeting it was "presumptuous for a national specialty society to try to use the AMA to interfere with the efforts of a state society."

In addition, Tenth District Trustee Ronald G. Welch, M.D., was commended by the AMA House of Delegates and the Illinois delegation for his work as chairman of Reference Committee A, the committee that researched the 12 recommendations for correcting RBRVS, the new Medicare physician payment system. ▲



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# HCFA prohibits use of superbills

by Tamara Strom

THIS IS NO April Fool's joke.

Effective April 1, physicians may no longer be allowed to use "superbills" for Medicare Part B claims. The U.S. Health Care Financing Administration published its intent to ban superbills and "other attachments" to the standard Medicare 1500 claim form in the *Federal Register* Nov. 29. The government will accept comments on the proposed rule until Jan. 28.

The Illinois State Medical Society is preparing a letter urging HCFA to abandon plans to deny superbills.

"At a time when the Medicare program is going through so many other alterations, such as physician pay-

ment reform, it seems more appropriate to allow physicians to become acclimated to the program changes before eliminating these convenient billing processes," said Alfred J. Kiesel, M.D., chairman of the ISMS Third Party Payment Processes Committee. "We encourage the government to retain physician flexibility in submitting claims."

ISMS policy reaffirmed at its 1991 annual meeting supports American Medical Association efforts to standardize billing across all third party payers with a universal claim form. But, Dr. Kiessel stressed, "Doctors should not be required to use the Medicare 1500 only." Blue Cross and Blue Shield of Illinois, the state's Medicare Part B carrier, notes, how-

ever, that in some instances it will be difficult to rely on superbills, because they lack specificity.

Blue Cross officials have noted, for example, that it is difficult to link a diagnosis with a procedure code on superbills, and they probably do not yet include the new RBRVS evaluation and management codes. Observers say inserting the correct information on the 1500 form may be to a physician's advantage.

HCFA says superbills and similar attachments to the 1500 form add administrative burden and raise costs. HCFA estimates up to 10 percent of all Medicare paper claims include these attachments. In Illinois, 36 percent of paper claims include superbills.

If the government gets its way, in April physicians must begin putting information they now include on su-

perbills in the correct spaces on the 1500 form. The only attachments HCFA will accept are those that provide medical evidence, certify medical necessity or that are required by law. If the proposed rule becomes final, any claims submitted using a superbill could be deemed incomplete and returned. Physicians may continue to circumvent the Medicare 1500 form by using electronic billing systems to submit claims.

In the next few months, HCFA will release a revised 1500 form, a "true universal claim form" that the Health Insurance Association of America – and all its member companies – are expected to accept. Even if an insurance company chooses to continue using its own forms, it should also accept the new 1500. Instructions on the new form will be

(continued on page 10)

## BuSpar® (buspirone HCl)

**References:** 1. Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology*. 1989;21:124-130. 2. Newton RE, Maruncz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med*. 1986;80 (suppl 3B):17-21. 3. Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med*. 1987;82 (suppl 5A):20-26.

**Contraindications:** Hypersensitivity to buspirone hydrochloride.  
**Warnings:** The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

**Precautions: General—Interference with cognitive and motor performance:** Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable, therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

**Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients:** Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdrawal patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

**Possible concerns related to buspirone's binding to dopamine receptors:** Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity, however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

**Information for Patients—**Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding, and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

**Drug Interactions—**Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations on SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

**Carcinogenesis, Mutagenesis, Impairment of Fertility—**No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

**Pregnancy: Teratogenic Effects—**Pregnancy Category B. Should be used during pregnancy only if clearly needed.

**Nursing Mothers—**Administration to nursing women should be avoided if clinically possible.

**Pediatric Use—**The safety and effectiveness have not been determined in individuals below 18 years of age.

**Use in the Elderly—**No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

**Use in Patients with Impaired Hepatic or Renal Function—**Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

**Adverse Reactions (See also Precautions): Commonly Observed—**The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

**Associated with Discontinuation of Treatment—**The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

**Incidence in Controlled Clinical Trials—**Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: **Cardiovascular:** tachycardia/palpitations 1%. **CNS:** Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. **EENT:** Blurred vision 2%. **Gastrointestinal:** Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. **Musculoskeletal:** Musculoskeletal aches/pains 1%. **Neurological:** Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. **Skin:** Skin rash 1%. **Miscellaneous:** Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

**Other Events Observed During the Entire Premarketing Evaluation—**The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. **Cardiovascular—**Frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. **Central Nervous System—**Frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, slupor, slurred speech, psychosis. **EENT—**Frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. **Endocrine—**rare: galactorrhea, thyroid abnormality. **Gastrointestinal—**infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. **Genitourinary—**infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. **Musculoskeletal—**infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. **Neurological—**infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. **Respiratory—**infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. **Sexual Function—**infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. **Skin—**infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. **Clinical Laboratory—**infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. **Miscellaneous—**infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

**Postintroduction Clinical Experience—**Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

**Drug Abuse and Dependence: Controlled Substance Class—**Not a controlled substance.

**Physical and Psychological Dependence—**Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

**Overdosage: Signs and Symptoms—**At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

**Recommended Overdose Treatment—**General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

U.S. Patent Nos. 3,717,634 and 4,182,763

MJL8-4270R2

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### SUSPECT PERSISTENT ANXIETY...

▲ Persistent anxiety can manifest as a variety of somatic and psychic symptoms

### RELIEVE IT WITH BuSpar®...

▲ Proven anxiolytic efficacy<sup>1</sup>

▲ Smooth, progressive action—relief starts within 1 week, progresses steadily through the fourth week of therapy<sup>1</sup>

▲ No more sedation (10%) than seen with placebo (9%)<sup>2</sup>

▲ Nonaddictive, no evidence of withdrawal syndrome<sup>3</sup>

▲ More commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%)

# BuSpar® 10mg

## (buspirone HCl)

### Progressive Relief of Persistent Anxiety.



## Budget woes

(continued from page 3)

said the state employees insurance plan "lends itself best to a multi-year solution."

Although the state employees insurance fund "never totally runs out of money," it will be approximately \$100 million short by June 30 when the fiscal year ends, said Helen Adorjan, spokesman for the Department of Central Management Services, the state agency that administers the fund. The \$100 million shortfall is up from the \$40 million deficit at the end of fiscal 1991. That deficit had to be covered by this year's appropriation, she said, leaving the state's self-insured fund in the hole as the fiscal year began.

This year marked the first time state employees are making premium contributions for their health insurance, as part of the budget agree-

ment that ended the legislative stalemate. Adorjan added that those monies, together with premiums for dependents, will keep revenue coming in all year.

However, by February the department will "really start scrutinizing the bills and doing some prioritizing," she said. "We'll be a little more careful about which ones we pay." She noted that preferred provider hospitals and bills for employees with continuing medical conditions who "absolutely must have their bills paid" will be paid first.

"It will still be a first-in, first-out basis," Adorjan said, "but within that parameter they will be prioritized. Everything that comes in during February will be paid before those that come in during March."

She admitted a slowdown in paying state employee medical bills already exists due to the state's revenue problems. ▲

## Spending cuts (continued from page 1)

we are having to make tough decisions as a result of a revenue shortfall caused by a national recession beyond our control. But now is a time not for regret, but for response."

Although he balked at across-the-board cuts during the legislative session in announcing his first budget, Edgar said the state's current fiscal situation warrants such cuts as the "fastest and fairest" means of effecting a \$350 million spending reduction.

"We set priorities in the budget we approved in July," Edgar said. "And those priorities will remain top priorities if we cut across the board now. I do not look forward to making further cuts in public aid or in mental health. But education and human service programs account for more than two-thirds of the General Revenue Funds budget."

The governor challenged lawmakers to give him carte blanche authority to make the 3 percent cuts or give him an "acceptable, fiscally responsible alternative" to eliminate \$350 million from the budget. "I remain open to your proposals for cutting the budget," he warned. "But I want

to stress that we do not have the luxury of debating the budget for four months as we did last spring and into the summer, program by program, item by item."

Edgar also stood firm on his campaign commitment not to raise income taxes. His pledge to again hold the line on taxes brought a standing ovation from the Republican side of the aisle.

"We simply must resist going back to our taxpayers again and again," he said. "Many of them are having a difficult time balancing their own budgets these days. I will not take this state down a federal government path paved by deficit upon deficit. We must cut and cut quickly."

But the governor's top priority, as it was in the spring, is to rid the state of its backlog of overdue Medicaid provider bills. "State government should not be a deadbeat," he said. "It has been embarrassing to me, and I'm sure to you, that the state has been delinquent in paying its bills and that the victims have been primarily health care providers."

Edgar said his borrowing plan will erase the backlog and reduce this year's payment cycle at the same time. Specifically, he said the state will borrow \$500 million, which will

Right, Joan Walters, Gov. Edgar's budget director, outlines the state's worsening fiscal condition during a Dec. 30 public hearing in Chicago. Walters pointed to rising health care costs among the additional spending pressures Illinois faces this year. Below, more than 100 senior citizens jammed the hearing room to protest any further cuts to the state's budget for human services this year. Many claimed they cannot pay for medications their doctors prescribe because the state's Circuit Breaker program, which pays for prescription drugs, limits seniors to \$800 per year. ▲



Wm. Daniels/The Photo Partners

be repaid by Oct. 1. Edgar acquiesced to the borrowing after refusing to consider it earlier because this plan meets his three criteria: the borrowing is not in lieu of spending cuts, it is short-term and there is an established repayment plan.

"Our innovative plan is based on bringing federal dollars into the state much more quickly than we had anticipated," he said. And his borrowing program does just that.

When the \$500 million in borrowed funds is used to pay Medicaid providers, the federal government will reimburse Illinois 50 cents on every dollar paid out, or \$250 million. The other \$250 million needed to repay the loan will come from Illinois hospitals and other health care

facilities under the state's new assessment program.

"Let us be innovative once again in claiming Illinois' fair share of federal dollars to meet our obligations to the needy and those who provide health care to the poor," Edgar said. "The assessment program was enacted to increase our federal aid for health care. We propose that it now be used to accelerate the flow of federal dollars into our state." ▲

## Superbills

(continued from page 9)

forthcoming, but until then, physicians should continue completing the 1500 form with the current instructions.

## More claim form confusion

A new regulation requiring physicians to include their UPIN (Unique Physician Identification Number) on some – but not all – Medicare claim forms is also causing confusion. Effective Jan. 1, physicians are required to include the UPIN and the names of referring physicians on all claims for referred or ordered services.

A claim must be accompanied by a UPIN when the billed procedure code indicates a referred or ordered service has been provided, such as a laboratory or radiological test, a consultation, or requests for durable medical equipment. The requirement is mandated by the Omnibus Budget Reconciliation Act of 1989.

Claims requiring a UPIN that are submitted without one will be denied or returned to the physician as incomplete. On claims submitted for other services that do not require a UPIN, physicians should continue to use their six-digit individual or group Medicare identification number for reporting. ▲

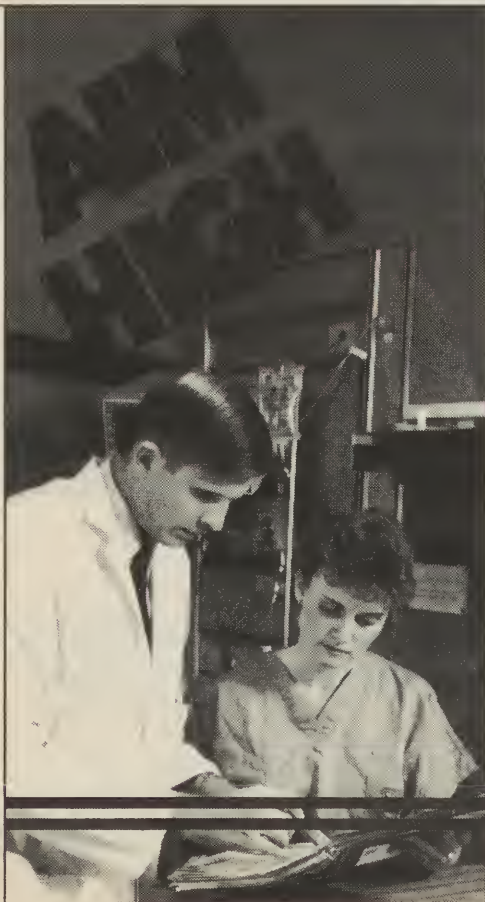
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# Caller ID blocking for free: dial \*67

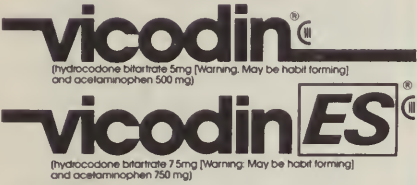
by Anna Brown

WHEN NORTHERN Illinois physicians call their patients from home, they can keep their telephone numbers private without calling the phone company or paying a fee. Caller ID, the controversial number display service available through Illinois Bell and Centel, may be blocked by pushing \*67 on a Touch Tone phone, or by dialing 1167 on a rotary phone, before dialing the call. Illinois Bell's service, begun Jan. 2, and Centel's, started in December, cover much of the northern Illinois area, including most of the 312, 708 and 815 area codes. "Caller ID is available through Illi-

nois Bell in 60 percent of the Chicago area," said Illinois Bell spokesman Laura Littel, noting that coverage could expand to 75 percent by the end of the year. "We've made about 1,000 sales a week since Dec. 2," she said. Centel's Caller ID is available in 100 percent of its service area, according to spokesman Claude Cliborne. That area includes Des Plaines, Park Ridge and parts of Chicago and other suburbs. He said 350 sales had been made out of a total 75,000 customers in the Chicago area. Caller ID allows anyone who has purchased a display unit to see incoming telephone numbers before

answering the phone. This technology drew the attention of the medical community when physicians became concerned about privacy issues. Illinois State Medical Society Immediate Past President James H. Andersen, M.D., wrote to the Illinois Commerce Commission last year regarding physicians' concerns about their home telephone numbers becoming available to patients without the doctors' knowledge or consent. Since then, the ICC ruled that Caller ID could only be offered if callers were allowed to block their telephone numbers at no charge. Both Illinois Bell and Centel provide that service, but blocking can only be done before each individual

phone call, not permanently. "Caller ID is a nuisance for physicians, but at least it can be blocked," said Dr. Andersen. "A preferable system would include free blocking 100 percent of the time for those who do not wish to dial extra numbers. Unlisted numbers should be blocked routinely, permanently and automatically." No pre-dialing is necessary if a call is made from an area that does not have Caller ID service, because no number will be displayed, Littel said. "In order for the number to be displayed, both ends must have the technology," she said. "It's up to the individual to make the decision whether to block each phone call," Littel said. ▲



**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.  
**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.  
**WARNINGS:**  
**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.  
**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.  
**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.  
**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.  
**PRECAUTIONS:**  
**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.  
**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.  
**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.  
**Use in Pregnancy:**  
**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.  
**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.  
**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.  
**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.  
**Pediatric Use:** Safety and effectiveness in children have not been established.  
**ADVERSE REACTIONS:**  
The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:  
**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.  
**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.  
**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.  
**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.  
**DRUG ABUSE AND DEPENDENCE:**  
VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.  
**OVERDOSAGE:**  
**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdosage may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.  
**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989  
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In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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Tablet for tablet, the most potent analgesic you can phone in.

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)  
1. Data on file, Knoll Pharmaceuticals  
2. Standard industry new prescription audit



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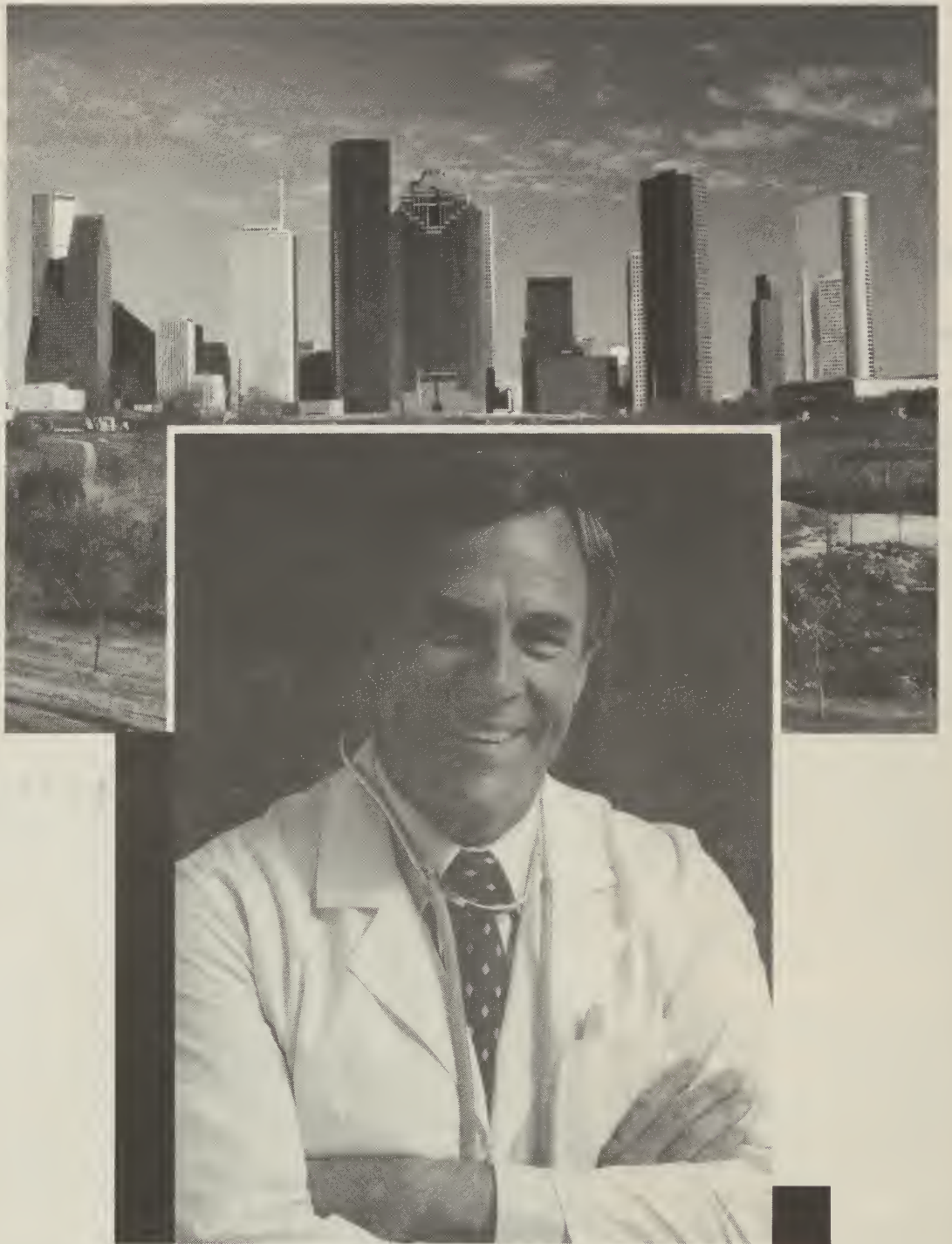
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# Members in the News

**Rolf M. Gunnar, M.D.**, of Maywood, was appointed chairman of the American College of Physicians' Board of Regents. Dr. Gunnar, who has pioneered research in treating shock following a heart attack, is medical director at MacNeal Hospital in Berwyn. The ACP is the second largest professional organization of physicians in the country.

**Steven N. Pector, D.O.**, of Des Plaines, joined the medical staff of



Rolf M. Gunnar, M.D.

Humana Hospital in Hoffman Estates. Dr. Pector received his medical degree from the Chicago College of Osteopathic Medicine. He is in private practice at Poplar Creek Family Practice in Hoffman Estates.

**Mary Frances Vanko, M.D.**, of Oak Lawn, joined the medical staff of Ingalls Memorial Hospital in Harvey. Dr. Vanko, who specializes in Ob/Gyn, received her medical degree from the University of Illinois College of Medicine at Chicago.

**Leo M. Henikoff, M.D.**, of Wilmette, was named chairman-elect of the Association of Academic Health Centers' Board of Directors. The AHC is a national organization of health complexes of major universi-

ties, including primary resources for education in the health professions, biomedical and health services research and patient care services. Dr. Henikoff has served on the AHC board since 1988, and is currently president of the Alpha Omega Alpha Honor Medical Society.

**Roman P. Smyk, M.D.**, of Coal City, received the Outstanding Citizen Award from the village board. Dr. Smyk was presented with a certificate of appreciation for his 36 years of medical service and dedication to the community.

**Robert P. Davis, M.D.**, of Chicago, was appointed chairman of the department of surgery at Columbus-Cabrini Medical Center in Chicago. Formerly director of continuing medical education at Columbus-Cabrini, Dr. Davis has been with the

medical center since 1975, and serves as director for transitional residency. Dr. Davis is also associate professor in clinical surgery at Northwestern University Medical School.

**Leon Love, M.D.**, of Glencoe, received the Stritch Medal for his work as a medical educator at the Loyola University Stritch School of Medicine's 40th annual awards dinner. Dr. Love is acting chairman and professor of radiology at Loyola. He is a 1946 graduate of the Chicago Medical School. ▲



Leon Love, M.D.

## AXID<sup>®</sup> nizatidine capsules

**Brief Summary. Consult the package insert for complete prescribing information.**

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

*Laboratory tests*—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

*Drug Interactions*—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

*Carcinogenesis, Mutagenesis, Impairment of Fertility*—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

*Pregnancy—Teratogenic Effects—Pregnancy Category C*—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

*Nursing Mothers*—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

*Pediatric Use*—Safety and effectiveness in children have not been established.

*Use in Elderly Patients*—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

*Hepatic*—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

*Cardiovascular*—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

*CNS*—Rare cases of reversible mental confusion have been reported.

*Endocrine*—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

*Hematologic*—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

*Integumental*—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

*Hypersensitivity*—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

*Other*—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Additional information available to the profession on request.



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1. Data on file, Lilly Research Laboratories.

See accompanying page for prescribing information.

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negotiations among ISMS, CMS and CCFMC failed to resolve the dispute in a timely manner. CCFMC on Dec. 5 informed ISMS Chairman George T. Wilkins Jr., M.D., that if ISMS planned to send such a letter, "... it might be better to forward your letter now."

The letter also cited CCFMC's continued delays in the performance of quality reviews, poor oversight of reviewers, the lack of physician reviewers in specialties other than internal medicine, and inadequate communication between CCFMC and physicians and hospitals.

"If these problems are not successfully addressed, existing physician perceptions about the serious lack of credibility of Medicare's peer review process will not only continue, but worsen," the letter stated.

#### Bylaws change sparked CMS dispute

In early 1990, CCFMC restructured its bylaws to limit membership on its former 26-member board to 16 physicians from its four original counties: Kane, Lake, McHenry and DuPage. The 10 board members representing other downstate counties, Illinois hospitals, CIMRO and the American Association of Retired Persons were appointed to a new Council for Governmental Review Programs, which also included the 16 CCFMC board members. Consequently, the letter says, "Appointments to this council and actions taken by it were subjected to oversight by the CCFMC board."

*"If these problems are not successfully addressed, physician perceptions about the serious lack of credibility of Medicare's peer review process will ... worsen."*

Triggering the dispute was an additional bylaws change that deleted CMS-appointed representatives to the council. Instead, those seats are now filled by an advisory referendum of CCFMC members in Cook County, with final appointment by the CCFMC board. CMS has objected to losing its ability to appoint those members, noting that CCFMC membership fails to include large numbers of CMS members.

"No review program can be credible when the opportunity to be represented - to have a say - is denied an organization that clearly represents the vast majority of Cook County physicians," the letter stated.

While CMS is the largest county medical society in the United States, the letter says, the degree of CCFMC membership in Cook County is unknown. "The figure we have commonly heard - 700 - pales in comparison to the 8,000 represented by CMS," it continued. (Further, the letter says, CCFMC has indicated it is considering appointing a representative to fill the slot previously filled by CIMRO.)

CMS strenuously objected to the bylaws changes when they were first

enacted and has been attempting to get CCFMC to reverse or modify the action ever since. ISMS initially attempted to mediate an agreement between CCFMC and CMS and a series of meetings and correspondence beginning in early November among ISMS, CMS and CCFMC representatives set the stage for the ISMS letter to HCFA.

On Nov. 6, ISMS hosted a meeting at which CMS asked CCFMC to restate the county medical society's appointment of three voting representatives to the CCFMC Council for Governmental Review Programs. In return, CMS pledged to "renew efforts to build CCFMC understanding among CMS physicians."

On Nov. 18, the CCFMC board responded by voting to invite two officers of CMS to sit as ex-officio mem-

bers of the council. In a joint letter dated Nov. 27, ISMS and CMS countered by saying CMS would "reluctant[ly]" accept two CMS-appointed representatives instead of three, but holding that "these two representatives need to be fully participating, voting members."

In a Dec. 5 letter to Dr. Wilkins, CCFMC President Gerald Lofthouse, M.D., said the CMS counterproposal would be discussed at the CCFMC board meeting on Jan. 20. He reiterated the offer of two ex-officio CMS representatives. "This offer was made in good faith and without demands or preconditions," Dr. Lofthouse wrote. "I respectfully ask that in the intervening weeks prior to my board's next meeting, the Chicago Medical Society reconsider its response, and in good faith, accept

this offer."

Dr. Lofthouse also wrote that he was aware of the ISMS board action authorizing what he called "a letter of nonsupport and condemnation of CCFMC's performance as the Illinois PRO." He said he understood a January deadline was agreed to "in the belief that submission of a critical letter in January was necessary to adversely affect HCFA's decision to renew our PRO contract. Given the short time frame involved, it might be better for you to forward your letter now. ... I believe that your request should be considered on its own merits, and not as part of a threat to interfere or actual interference with our contract."

CIMRO has said it would bid on a new statewide contract if HCFA reopened the bidding process. ▲

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# Medical school director touts research at UI Peoria

by Anna Brown

IN HIS FIRST year at the University of Illinois School of Medicine at Peoria, Director Michael Bailie, M.D., Ph.D., knows exactly where his school is going. Within the next few months, he announces proudly, a private corporation will move into the medical school building and set up shop with a new clinical research and training program.

"The Peoria Medical Research Corp. is a cooperative effort between local hospitals and a group of businesses and industries that have formed a private corporation to help develop clinical research in the state of Illinois," says Dr. Bailie, who joined the university in June. Together with the medical school, the corporation forms the core of what will include an expansion of faculty and grants coming into Peoria over the next several years.

"We're off and running," says Dr. Bailie. "We recently received the go-ahead to do some renovations so that we can handle the new faculty we're going to be hiring in the next couple of years."

The state is helping to fund the project, and Dr. Bailie hopes the federal government will contribute in the future.

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*"Are we going to have some kind of health plan that's going to have access for everybody? Who's going to pay for it? Are people who finally go to hospitals only going to be the very sickest? These are challenging questions that we're going to have to address."*

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"This is a very, very unique opportunity for the University of Illinois, and the medical school," says Dr. Bailie. "It has a lot of potential."

"One of the issues that came up when I came here was, What was unique about this program? What should our niche really be?" he says. "Each site [in the Illinois program] has the opportunity to develop something that is unique." For Peoria, it is the research program, he says.

## One of four sites

The medical school at Peoria has a three-year curriculum that, together with sites at Urbana and Rockford, constitutes a four-year medical program under the auspices of the main medical campus at Chicago. Of the 300 applicants accepted each year into the University of Illinois School of Medicine, 175 attend a four-year program at Chicago. One hundred twenty-five students attend their first year at Urbana, and 25 of those remain to complete their medical degrees. The remaining 100 students complete their final three years at Rockford or Peoria.



Photo: Linda Henson

UI Peoria medical school Director Michael Bailie, M.D., says when the medical school first opened in 1970, 80 percent to 90 percent of funds came primarily from the state of Illinois. Now, he says, "We're getting only about half of our support from state dollars, and the rest, more than 50 percent, is coming from grants and faculty earnings. This is a problem."

"When I came to visit Peoria about a year ago, I found that it was a very exciting program," says Dr. Bailie. "It is small. We have 50 students a year here, which is certainly more manageable than the larger programs I've been associated with. That was one of the nice things."

Prior to accepting his current position, Dr. Bailie chaired the department of pediatrics at the University of Connecticut School of Medicine from 1983-89, but returned to teaching in his last two years there. Seeking a new administrative position, the Indiana native says he was glad to find one in the Midwest. He received his medical degree in 1964 and a Ph.D. in physiology in 1966 from Indiana University.

He served his internship and one-year residency at Stanford University and spent two years in Dallas as a fellow in the department of internal medicine, Division of Nephrology at the University of Texas Southwestern Medical School. In 1970, he received a joint appointment in physiology and human development and pediatrics at Michigan State University. He also served as chairman of pediatrics at the University of Kansas, where he was director of the Children's Rehabilitation Unit.

Dr. Bailie expresses concern about the future of medical education, and believes changes will have to be made to take medicine into the next century.

"I think the most rewarding part of my job will be, eventually, seeing the faculty and the students actively involved in looking at ways of improving our curriculum and looking at new approaches of educating students and residents," he says. "This is a critical time for medicine. I am a firm believer that all individuals need primary care providers of some kind. We need to encourage more students to go into primary care, and to look for ways of making primary care more attractive to students."

"What it amounts to is, you're trying to guess how medicine is going to be practiced in this country for the next 30 years," he says. "Are we going to have some kind of health

plan that's going to have access for everybody? Who's going to pay for it? Are we going to have more and more patients being seen outside of hospitals? Are people who finally go to hospitals only going to be the very sickest? Are hospitals going to hire physicians to care for those patients rather than having the private physicians come in as they do now? What about prevention and health maintenance?"

"It's a very complicated time for medical education, and these are challenging questions that we're going to have to address," Dr. Bailie continues. "We're going to sit down and look at all of those things and come up with some estimate that says, 'This is the kind of education we should be providing.' We will begin to shift our education from inpatient to outpatient. We will look for educational opportunities in rural areas vs. within the city. When you're out here in the middle of some of the most fertile farmland in the world, you need to look at ways of providing people who live here with good access."

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*"This is a critical time for medicine. I am a firm believer that all individuals need primary care providers of some kind. We need to encourage more students to go into primary care."*

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And here is where the new research project comes into play, as Dr. Bailie actively seeks ways for the medical school to interact with the community. The Peoria Medical Research Corp. will serve as that link, he says, as it becomes a catalyst for developing innovations in medical education.

"We recently hired a new patholo-

gist," says Dr. Bailie. "Her area of scholarship is going to be education. She is really interested in how to better teach medical students pathology and other kinds of clinical areas."

## A cooperative effort

Dr. Bailie says one reason he came to Peoria is because he was impressed by the interaction between the medical school and local hospitals. St. Francis Medical Center provides the majority of the residency programs for the medical school, and Methodist Medical Center primarily houses the family practice residency program, he says.

"In this day and age, in order to have a residency program, a hospital really needs a medical school affiliation," says Dr. Bailie. "The hospitals realize that if they want residency programs they have to work with the medical schools to maintain those programs, and the medical school recognizes that we have to have a hospital and ambulatory sites to train medical students and run our education program. We need each other."

Despite good community relationships, Dr. Bailie says the Peoria program is not without some problems. As with many other educational institutions, the program faces financial woes. One of his concerns is that education is being supported more and more by faculty practices, rather than by the state.

"At one time, when the school first opened in 1970, 80 percent to 90 percent of funds came primarily from the state of Illinois. Now we're getting only about half of our support from state dollars, and the rest, more than 50 percent, is coming from grants and faculty earnings," he laments. "This is a problem. As the state support shrinks, we have to look at other ways to support our programs locally."

While financial problems have grown over the years, problems of the past have managed to resolve themselves. When the program began, local physicians worried about competition and hospitals worried that the medical school wanted to take them over, says Dr. Bailie. The medical school worried that physicians in private practice couldn't teach.

Dr. Bailie says that as medical school programs formed in the late '60s and early '70s matured, many of these issues were resolved. "We've found that the people who were here were active in the program from the beginning and continue to be active and excellent teachers," he says. "The hospitals found that the medical school could attract certain kinds of practitioners who might not come here without the program. The local physicians found that for the most part — and some of them still find it difficult — the competition from the medical school physicians was not harmful, but made the community more attractive for health care."

"One of the reasons that health care is the second largest employer in this community is due at least in part to the presence of the medical school," he says. "I want us to be more involved in the community of Peoria, and this region, not just Peoria itself." ▲



Rural clinic (continued from page 1)

will get earlier access to quality care.”

More than 160 physicians donate time, either at the clinic, in their offices or at one of three hospitals that have agreed to provide free services to clinic patients, Watkins told *Illinois Medicine*. St. Francis Medical Center, Methodist Medical Center, and Proctor Community Hospital donate services to Heartland patients on a rotating basis.

“December was Proctor’s month,” Watkins explained, noting that diagnostic work or needed inpatient care is provided free. If a patient is admitted to a hospital and remains there into the next month, he or she will not be transported to another hospital. But if a patient receives diagnostic tests over the course of several months, the tests will rotate among the hospitals each month, she said. “We are attempting to provide both quality comprehensive care and continuity of care,” Watkins said.

Addressing a need

Heartland is modeled after the free Will-Grundy Clinic in Joliet, and the Judeo-Christian Clinic in Tampa, Fla. Heartland and Will-Grundy provide primary health care services and are open two half days a week. “Will-Grundy has maintained its

schedule for the past four years, but we feel the need to be more flexible,” Watkins said. Heartland has approached this need by opening three specialty offices for a half day a month. “The specialties, which include Ob/Gyn, ENT and neurology, are primarily for our referrals.

“We’re seeing an average of 17 patients per clinic day,” she continued. “We’ve seen all new patients, and we have a phone line open for sick call.” Watkins explained that since the state terminated public assistance to single people, many have not been able to find the care they need, and have come to Heartland.

Major renovation

Heartland Community Clinic is located in downtown Peoria, in the former residence of Bishop O’Rourke, a building purchased from the Catholic diocese. Six weeks of renovation totaling \$75,000 completed the addition of four exam rooms, two handicap-accessible bathrooms and an admission room/lab. Staff moved in Nov. 20 to prepare for a Dec. 8 open house.

“Almost everything was donated, from equipment to office furnishings,” Watkins said. “Lincoln Office designed the waiting room and supplied the furnishings, which was very generous. Even the computer was donated. We’ve had a wonderful response from the community.” ▲

Obituaries

\* indicates ISMS member  
\*\* indicates member of ISMS Fifty Year Club

\*Branit

Joseph T. Branit, M.D., of Chicago, died October 17, 1991 at the age of 66. Dr. Branit was a 1949 graduate of the University of Illinois College of Medicine, Chicago.

\*\*FitzGibbons

James P. FitzGibbons, M.D., of Evanston, died October 18, 1991 at the age of 83. Dr. FitzGibbons was a 1936 graduate of Loyola University Stritch School of Medicine, Maywood.

\*Grigg

Mary M. Grigg, M.D., of River Forest, died September 3, 1991 at the age of 69. Dr. Grigg was a 1947 graduate of Institut de Medicina si Farmacie, Bucuresti, Romania.

\*\*Hedberg

Carl A. Hedberg, M.D., of Winnetka, died October 27, 1991 at the age of 91. Dr. Hedberg was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

\*\*Irwin

George H. Irwin, M.D., of Coudersport, Pa. (formerly of Chicago), died September 16, 1991 at the age of 96. Dr. Irwin was a 1921 graduate of Rush Medical College, Chicago.

\*\*Kuhlman

Ralph Kuhlman, M.D., of Red Bud, died September 29, 1991 at the age of 84. Dr. Kuhlman was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

\*Maran

Erik Maran, M.D., of Morton, died September 29, 1991 at the age of 75. Dr. Maran was a 1946 graduate of Medizinische Fakultät der Eberhard Karls Universitaet, Tubingen, Baden-Wuerttemberg, Germany.

\*Redondo

Diego Redondo, M.D., of Deerfield, died September 28, 1991 at the age of 55. Dr. Redondo was a 1961 graduate of Tulane University School of Medicine, New Orleans, Louisiana.

\*\*Schaller

Edward H. Schaller, M.D., of Waterloo, died August 14, 1991 at the age of 86. Dr. Schaller was a 1928 graduate of Washington University School of Medicine, St. Louis, Missouri.

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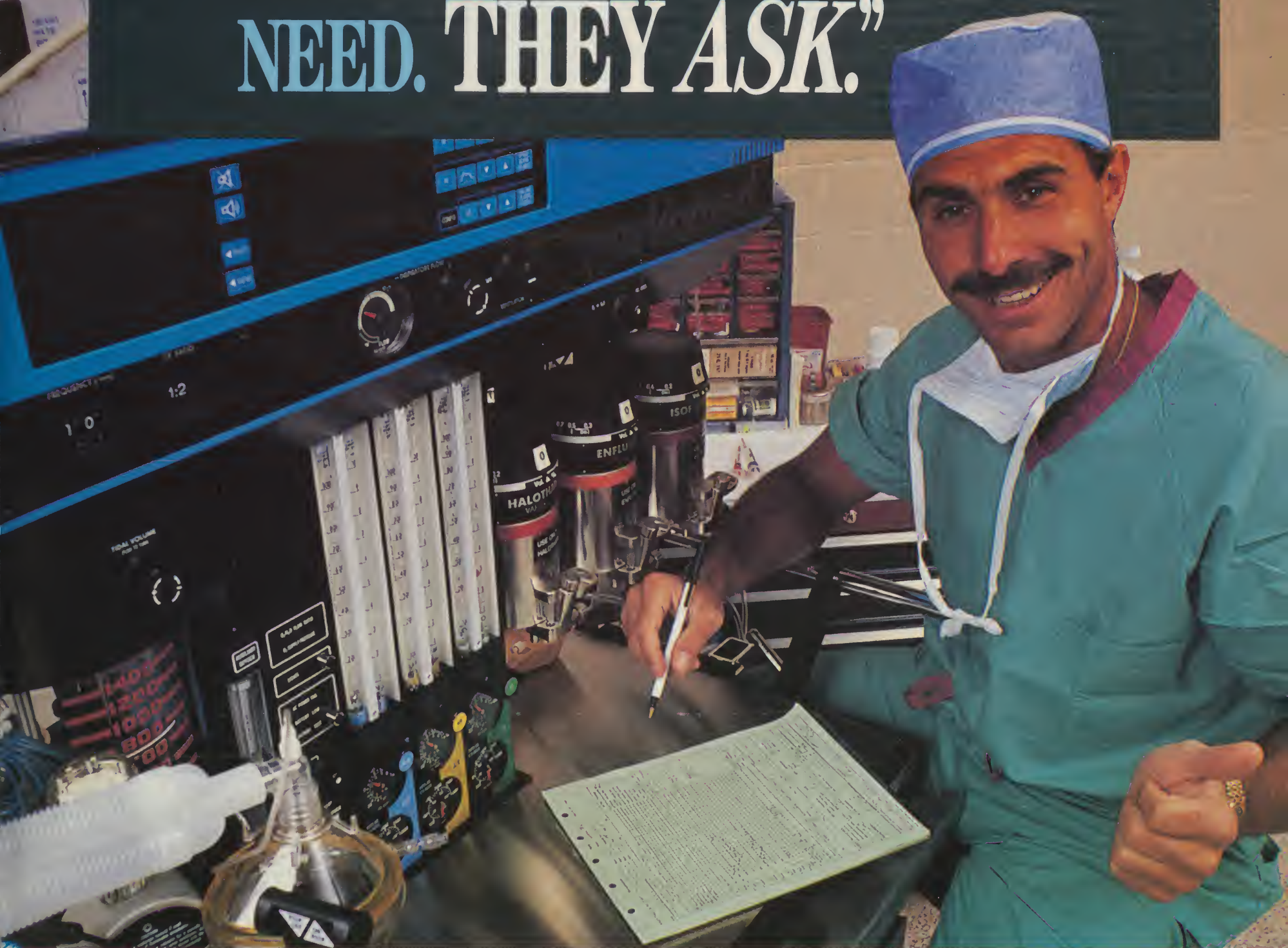
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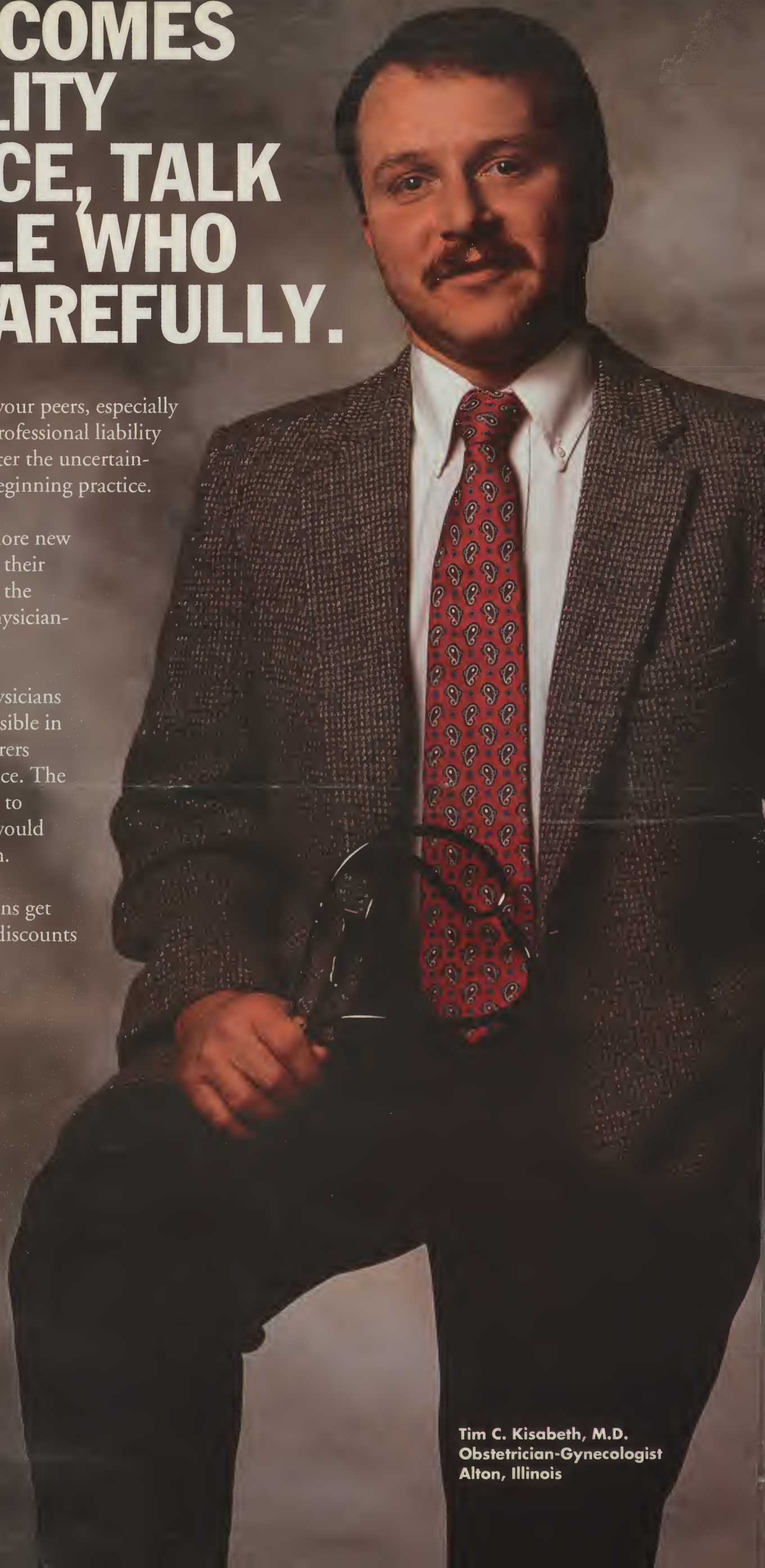
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# Illinois Medicine

Auxiliaries look forward to exciting year of mini-internships... 8

January 31, 1992

ILLINOIS STATE MEDICAL SOCIETY

## ISMS Annual Meeting moves to Oak Brook Hills Hotel

IF YOU were planning to travel to the Westin O'Hare Hotel for the 1992 Illinois State Medical Society Annual Meeting,

please change your itinerary. The April 10-12 meeting is changing locations to Oak Brook Hills Hotel in Oak Brook. Physicians interested in submitting resolutions for the ISMS House of Delegates must do so by March 10, 1992. Resolutions not received at ISMS headquarters in Chicago by 4:45 p.m. on the deadline date will be considered late and will require special action for possible consideration. See you in Oak Brook! ▲



"Where is everybody?"

## Governor's AIDS task force making progress

by Anna Brown

CONFIDENTIALITY issues dominated the discussion at the third meeting of Gov. Jim Edgar's Task Force on AIDS in Health Care Jan. 13 in Chicago.

"I think we'll be able to meet our April 1 deadline and give the governor the best report we can," said Nestor Ramirez, M.D., task force chairman.

The report will address issues of HIV exposure in health care settings, prevention of transmission, disclosure, patient confidentiality

and how to best allocate limited state resources to implement S.B. 999, the HIV Notification Act, and the U.S. Centers for Disease Control guidelines to prevent transmission of HIV in health care settings. Subcommittees were formed at the first meeting to formulate suggestions on each of these topics.

The task force will report its recommendations to the Illinois Department of Public Health this spring in order to have input on the rules currently being developed by the department to implement S.B. 999.

"The task force's focus is very scientific, very reasonable and very humane," Dr. Ramirez told *Illinois*

*Medicine*. "We are not out to punish anybody or to judge anybody for having a disease, or for being contagious or having a positive test. Our task is to educate, to prevent, and to make sure that everybody has their confidentiality and their rights protected at all times."

### Ideas, not recommendations

At this, the third of five scheduled meetings, the group discussed in general terms ideas developed during various subcommittee meetings. No decisions on final recommendations were made.

It was apparent that one major area of concern for

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Government promises stiff fines for breaking law

## Deadlines approach for physician compliance with OSHA regulations

by Tamara Strom

AS THE EFFECTIVE dates for new federal regulations on bloodborne pathogens loom, physicians should be bringing their offices into compliance. The first dead-

line for partial compliance with the U.S. Occupational Safety and Health Administration rules is March 5.

The idea behind the new OSHA regulations is to put "full legal force" behind the implementation of universal precautions, according to an American Medical Association videotape aimed at helping physicians comply. One of the most ominous aspects of that force is civil

monetary penalties for non-compliance.

Failure to adhere to the provisions of the standard will result in stiff fines, according to OSHA. For example, the new maximum fine is \$70,000 for each willful or repeated violation and \$7,000 for each other serious violation. Some violations carry \$7,000-per-day fines for non-compliance.

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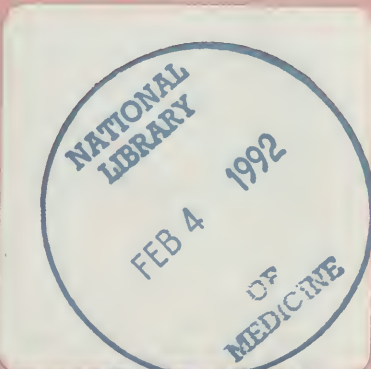
## ISMS announces first Employee of the Month award winner

by Kevin O'Brien

THE ILLINOIS State Medical Society Jan. 10 named John Moss the first ISMS Employee of the Month award winner. Alexander R. Lerner, chief executive officer of ISMS and the Illinois State Medical Inter-Insurance Exchange, presented the awards in a brief ceremony at the Society's offices in Chicago.

The Employee of the

(continued on page 10)



Employee of the Month John Moss

Photo: Wm. Danie

## Chicago-area PPO to expand with Evangelical purchase

by Anna Brown

EVANGELICAL HEALTH Systems announced Jan. 10 that it has purchased 50 percent interest in Lutheran General Health Care System's managed care subsidiary, Parkside Health Management Corp. Officials of the two health care organizations predict the joint venture will become the leading provider-owned managed care enterprise in the Chicago market by 1995.

Parkside operates PATH PPO, one of the Chicago area's largest preferred provider organizations. The purchase will have the immediate result of adding



Evangelical's 10,000 employees and their dependents to PATH PPO, which currently serves 85,000 people in 35 hospitals throughout the Chicago area, and reaches as far west as the Quad Cities.

Prior to the purchase, Evangelical had no managed care plan, but had investigated forming a PPO for its own employees, said Richard R. Risk, Evangelical's interim president and chief executive officer. The Parkside purchase resulted in savings, he said, but he declined to reveal the amount invested in the

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## IDPH fines Effingham hospital \$10,000

St. Anthony's Memorial Hospital in downstate Effingham will appeal the \$10,000 fine levied against it by the Illinois Department of Public Health. The deadline to pay the fine was Jan. 15, but hospital officials requested a public hearing instead.

The fine is the result of an October incident that allegedly caused an emergency room patient's death because no surgeons were on call. Although St. Anthony's has since withdrawn from the state's trauma system, at the time of the incident it was a Level II trauma center, which required the hospital to have at least two surgeons available at all times.

Referring to the citation in the Illinois Code that permits such penalties, IDPH spokesman Tom Schafer said the department fined St. Anthony's for creating a condition "presenting a substantial probability that death or serious physical harm to an individual will result." In other words, Schafer said, the department believes the hospital failed to provide a surgeon within 30 minutes for a patient in need of surgery, and failed to have policies in place to ensure the availability of a surgeon within 30 minutes.

The \$10,000 fine is the maximum IDPH can levy to penalize institutions that do not adhere to the rules governing the state's trauma system, Schafer said. The department received authority to levy fines from the General Assembly in July 1991. The St. Anthony's fine is the first such action against a member or former member of the Illinois trauma system.

Meanwhile, Sarah Bush Lincoln Health Center in Mattoon joined St. Anthony's as the second institution during 1991 to drop its designation as a Level II trauma center in 1991.

Although both hospitals cite declining participation in the trauma system statewide, IDPH disputes that claim. While a national trend toward decreasing numbers of trauma centers is occurring, Illinois is not experiencing the same flight of hospitals from its system.

With Sarah Bush Lincoln's withdrawal, the Illinois trauma system currently has 18 Level I trauma centers and 57 Level II centers.

## Planning board OKs Provident CON changes

The Illinois Health Facilities Planning Board Jan. 16 approved a request by Cook County to revise its certificate of need for renovating Provident Hospital in Chicago. The revised proposal calls for an overall reduction in the number of beds from 275 to 242. The county still hopes to reopen Provident in 1993 to absorb some of the patient load from Cook County Hospital.

Although the county is reducing the number of medical-surgical, pediatric and intensive care beds, it proposes expanding the obstetrical unit by 11 beds. In addition, officials propose adding six labor-delivery-recovery-postpartum rooms, enlarging the nurseries and adding three more traditional labor rooms to encourage county residents to choose Provident for OB care.

"To demonstrate its commitment to humane maternity care, the county decided to build six [LDRPs], making available for the first time to county clientele this attractive birthing option," the revised proposal states. "Although scores of thousands of healthy deliveries have been made at Cook County Hospital over the years, the physical environment there is far from ideal." ▲

— Compiled by Tamara Strom

## ISMS-HMSS annual meeting Feb. 8

EDUCATIONAL sessions on RBRVS coding issues, advance directives and the Illinois Health Care Surrogate Act will be featured at the seventh annual meeting of the Illinois State Medical Society's Hospital Medical Staff Section. The meeting will be held on Saturday, Feb. 8, from 9 a.m. to 4 p.m. at the ISMS Conference Center in Chicago.

Following the education sessions, delegates will consider revisions of the ISMS-HMSS bylaws. A business meeting in the afternoon will include election of governing council officers and consideration of proposed resolutions to be submitted to the ISMS House of Delegates annual meeting in April.

Each hospital medical staff in Illinois is eligible to elect medical staff representatives to attend the meeting. Representatives must be ISMS members and have active clinical privileges. For further information, contact the ISMS Hospital Medical Staff Section at (312) 782-1654. ▲



Dennis M. Brown, M.D., chairman of the ISMS-HMSS governing council.

## New surgicenter planned for Aurora

by Tamara Strom

AURORA'S DREYER Medical Clinic has announced that, with health care dollars and resources becoming more scarce all the time, the clinic plans an outpatient surgical center. Clinic officials say patients will receive lower-cost services than the two local hospitals can provide.

Although both Copley Memorial Hospital and Mercy Center for Health Care Services have full-service outpatient surgical departments, clinic officials believe a low-cost surgical center is necessary. The surgicenter, slated to open in July 1993, would offer "just about all outpatient surgeries," including ophthalmology, orthopedic, urology, general and obstetrical-gynecological, according to Dreyer officials.

"The need for such a center is a cost-based one, particularly for our HMO patients," said Leonard Snyder, M.D., chairman of Dreyer's board of directors. "We can do it much cheaper than the hospitals [and it will be] better for our patients cost-wise."

Dr. Snyder said Dreyer's cost estimates for services at the clinic will average \$409 less, per procedure, than the hospitals in town. "With the way the price of medical care is going nowadays, you have to do what you can to cut costs," he noted. Dr. Snyder said Dreyer physicians expect to perform about 5,500 to 6,000 outpatient surgeries in the clinic's first few years of operation. This total would cover anticipated construction costs of about \$4 million, he said.

If approved by the Illinois Health Facilities Planning Board, the surgicenter will be built on land adjacent



Leonard Snyder, M.D. (left), chairman of Dreyer's board of directors; and Marvin Kolb, M.D., Mercy's medical director, both pointed to the need for more obstetricians in the Aurora area.



to Mercy's campus on the west side of Aurora. Dr. Snyder said Dreyer is expecting a March or April appearance before the board.

### Copley rejects offer

Dreyer originally asked both Aurora hospitals to join the venture as 20 percent partners, but only Mercy accepted the offer. Now a 40 percent partner in the surgicenter, Mercy will contribute 40 percent of the operating costs and will ultimately receive 40 percent of the profits. However, "Revenue will not flow in for a while," cautioned Dreyer President John Potter.

Although Mercy will lose revenue from lost outpatient surgeries, the hospital will recoup some of that money through its interest in the surgicenter. "We recognize that our prime purpose is to enhance our cooperative relationship with our physicians and joining the surgicenter is one way to accomplish that," said Marvin Kolb, M.D., Mercy's medical director. "Some aspects [of the affiliation] are a loss for Mercy and some are gains for Mercy and the city of Aurora."

"But the positives outweigh the negatives," Dr. Kolb added. "We must be aggressive and active in

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## Corrections and Clarifications

In the interview with Cardinal Joseph Bernardin in the Nov. 22 issue, we incorrectly referred to the Catholic Conference of Illinois as the policy-making arm of the Archdiocese of Chicago. The Catholic Conference of Illinois is the inter-diocesan organization that represents the interests of the six dioceses of Illinois in state legislative matters. *Illinois Medicine* regrets the error. ▲

## Physician Facts

### The average annual cost of health care for families in the 10 most expensive states

1. New York	\$5,585
2. Connecticut	\$5,421
3. Massachusetts	\$5,321
4. Rhode Island	\$4,914
5. New Jersey	\$4,863
6. Illinois	\$4,670
7. Hawaii	\$4,696
8. Michigan	\$4,569
9. Minnesota	\$4,568
10. Maryland	\$4,484
U.S. average	\$4,296



Source: Families USA Foundation, Washington, D.C. For this study, a family was defined as one or more persons in one residence who are related by birth, marriage or adoption.

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# You can haul it yourself: Most physician offices exempt from medical waste law

by Tamara Strom

SINCE ILLINOIS' NEW medical waste disposal law went into effect Jan. 1, waste hauling firms have stepped up efforts to entice physicians to sign contracts with them. But while having a hauler cart away a physician's medical waste may be convenient, it is not always necessary. Physician offices generating less than 50 pounds of medical waste a month, (which most do), are exempt from the specific transporting, permit and manifesting requirements of the law.

"This exemption for small generators is a product of the governor's Medical Waste Tracking Study Group," said Illinois State Medical Society President Robert M. Reardon, M.D. "The physicians who served on the committee to make recommendations on the law's implementation worked hard for these exemptions that should make compliance with the new standard relatively painless."

Final rules for the statute are expected in late spring or early summer, but until the rules are released, physicians are bound to comply with the provisions of the law as written.

Specifically, physicians can take their medical waste to any landfill that will accept such waste. Sharps, however, must be separated from other medical waste, and landfills are prohibited from taking sharps that have not been treated. Treated sharps are those that are made unrecognizable through grinding or other similar process.

Physicians can dispose of sharps at hospital incinerators, provided they have an agreement with the hospital to do so and are on staff at the hospital.

Despite all this, some physicians may find it more convenient to hire a waste hauler. Some suburban and downstate waste hauling firms currently charge about \$30 a month for such a service, while prices are higher in urban areas such as Chicago.

"Physicians have a choice about how they choose to dispose of waste from the office," Dr. Reardon said. "We want them to know that they have options other than contracting with a waste hauler."

Regardless of how a physician chooses to dispose of the waste, certain waste labeling requirements are mandated in the new law. All sharps containers and infected waste bags must be identified as medical waste and must carry the official biohazard label. These labels are readily available at medical supply houses.

Waste that contains sharps must be clearly marked as such on the outside. The bag or container also must be labeled with the physician's name, address and 24-hour telephone number. Doctors may continue to use sealed coffee cans as sharps containers under the new law as long as they are puncture-resistant and leak-proof. The cans also must be labeled properly.

## Chicago regulations differ

For physicians practicing in Chicago, complying with medical waste legisla-

tion is a little more complicated. The city's year-old medical waste ordinance poses more challenging disposal requirements for physicians, but is a "reasonable law," said M. LeRoy Sprang, M.D., Chicago Medical Society president. Dr. Sprang was part of the negotiating team that helped lawmakers and health department officials formulate the law.

"Compliance is relatively easy," Dr. Sprang told *Illinois Medicine*. "It poses no great burden for physi-

cians. The medical society's input made the restrictions significantly more reasonable. The initial draft regulations were more stringent and restrictive, but the final law is realistic. It's based on common sense and still achieves a meaningful improvement over the past system."

The city ordinance differs from the Illinois law in that Chicago physicians may only transport up to six pounds of medical waste from their offices to a legal dump site monthly.



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**Hopedale**  
**Jacksonville**  
**Jerseyville**  
**Joliet**

**Kankakee**  
**Kewanee**  
**LaGrange**  
**Lawrenceville**  
**Lincoln**  
**Litchfield**  
**Macomb**  
**Marion**  
**Maryville**  
**Mattoon**  
**McHenry**  
**McLeansboro**  
**Melrose Park**  
**Mendota**  
**Metropolis**  
**Moline**  
**Monmouth**  
**Monticello**  
**Morris**  
**Morrison**  
**Mount Carmel**  
**Mount Vernon**

**Murphysboro**  
**Nashville**  
**Normal**  
**Oak Lawn**  
**Oak Park**

**Olney**  
**Olympia Fields**  
**Ottawa**  
**Palos Heights**  
**Pana**  
**Paris**  
**Park Ridge**

**Pekin**  
**Peoria**  
**Peru**  
**Pinckneyville**  
**Pittsfield**  
**Pontiac**  
**Princeton**  
**Quincy**

**Red Bud**  
**Robinson**  
**Rochelle**  
**Rock Island**  
**Rockford**

**Rosiclare**  
**Rushville**  
**Salem**  
**Sandwich**  
**Savanna**  
**Shelbyville**  
**Sparta**  
**Spring Valley**  
**Springfield**  
**Staunton**

**Sterling**

**Edward A. Ullaut Memorial Hospital**  
**Harrisburg Medical Center**  
**Mason District Hospital**  
**South Suburban Hospital**  
**Herrin Hospital**  
**St. Joseph's Hospital**  
**Highland Park Hospital**  
**Hillsboro Hospital**  
**Hinsdale Hospital**  
**Humana Hospital**  
**Hoopeston Community Memorial Hospital**  
**Hopedale Medical Complex**  
**Passavant Memorial Area Hospital**  
**Jersey Community Hospital**  
**Silver Cross Hospital**  
**St. Joseph Hospital**  
**Riverside Medical Center**  
**Kewanee Public Hospital**  
**LaGrange Memorial Hospital**  
**Lawrence County Memorial Hospital**  
**Abraham Lincoln Memorial Hospital**  
**St. Francis Hospital**  
**McDonough District Hospital**  
**Marion Memorial Hospital**  
**Anderson Hospital**  
**Sarah Bush Lincoln Health Center**  
**Northern Illinois Medical Center**  
**Hamilton Memorial Hospital**  
**Westlake Community Hospital**  
**Mendota Community Hospital**  
**Massac Memorial Hospital**  
**United Medical Center**  
**Community Memorial Hospital**  
**John & Mary E. Kirby Hospital**  
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**Morrison Community Hospital**  
**Wabash General Hospital**  
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**Good Samaritan Regional Health Center**  
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**Washington County Hospital**  
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**Oak Park Hospital**  
**West Suburban Hospital Medical Center**  
**Richland Memorial Hospital**  
**Olympia Fields Osteopathic Medical Center**  
**Community Hospital of Ottawa**  
**Palos Community Hospital**  
**Pana Community Hospital**  
**Paris Community Hospital**  
**Lutheran General Hospital**  
**Parkside Lutheran Hospital**  
**Pekin Memorial Hospital**  
**St. Francis Hospital Medical Center**  
**Illinois Valley Community Hospital**  
**Pinckneyville Community Hospital**  
**Illini Community Hospital**  
**St. James Hospital**  
**Perry Memorial Hospital**  
**Blessing Hospital**  
**St. Mary Hospital**  
**St. Clement Hospital**  
**Crawford Memorial Hospital**  
**Rochelle Community Hospital**  
**Franciscan Medical Center**  
**Rockford Memorial**  
**St. Anthony Medical Center**  
**Swedish American Hospital**  
**Hardin County General Hospital**  
**Sarah D. Culbertson Memorial Hospital**  
**Public Hospital of the Town of Salem**  
**Sandwich Community Hospital**  
**Savanna City Hospital**  
**Shelby Memorial Hospital**  
**Sparta Community Hospital**  
**St. Margaret's Hospital**  
**Memorial Medical Center**  
**Community Memorial Hospital Association**  
**Community General Hospital**

**Streator**  
**Sycamore**  
**Taylorville**  
**Tuscola**

**Urbana**  
**Vandalia**  
**Waukegan**  
**West Frankfort**  
**Wheaton**  
**Winfield**  
**Wood River**  
**Woodstock**

**St. Mary's Hospital**  
**Sycamore Hospital**  
**St. Vincent Memorial Hospital**  
**Douglas County Jarman Memorial Hospital**  
**Covenant Medical Center Urbana**  
**Fayette County Hospital**  
**Iroquois Memorial Hospital**  
**Saint Therese Medical Center**  
**U.M.W. of A. Union Hospital**  
**Marianjoy Rehabilitation Hospital**  
**Central DuPage Hospital**  
**Wood River Township Hospital**  
**Memorial Hospital for McHenry County**

Dr. Sprang noted that most physicians contract with licensed waste hauling firms to pick up the waste and dispose of it in accordance with the regulations.

Hauling firms provide legal disposal bags the doctor or office staff seals when full. These sealed bags are then placed into a box (also provided by the hauling firm) and the box, too, is sealed. "So there is a fair amount of safety," Dr. Sprang noted.

Chicago physicians also must maintain a waste management plan in their offices that outlines the practices for the handling and preparation for disposal of infectious waste.

Dr. Sprang said the Chicago Medical Society has prepared a sample plan that has been approved by the Chicago Department of Health and makes copies available to physicians. ▲

### INDIANA

**Dyer**  
**East Chicago**  
**Evansville**  
**Gary**

**Hammond**  
**Hobart**  
**LaFayette**

**Merrillville**  
**Michigan City**  
**Munster**  
**South Bend**  
**Terre Haute**

**Our Lady of Mercy Hospital**  
**St. Catherine Hospital**  
**Welborn Memorial Baptist Hospital**  
**Methodist Hospital**  
**St. Mary Medical Center**  
**St. Margaret's Hospital**  
**St. Mary Medical Center**  
**St. Elizabeth Hospital & Medical Center**  
**Methodist Hospital**  
**Memorial Medical Center**  
**The Community Hospital**  
**St. Joseph's Hospital**  
**Terre Haute Regional Hospital**

### IOWA

**Clinton**  
**Davenport**  
**Dubuque**  
**Keokuk**

**Samaritan Health Systems**  
**Mercy Hospital**  
**Finley Hospital**  
**Keokuk Area Hospital**

### MISSOURI

**Chesterfield**  
**Hannibal**  
**St. Louis**

**St. Lukes Hospital**  
**Hannibal Regional Hospital**  
**Barnes Hospital**  
**Cardinal Glennon Children's Hospital**  
**Christian Hospital NE Division**  
**Christian Hospital NW Division**  
**Jewish Hospital**  
**SSM Rehabilitation Institute**  
**St. Anthony's Medical Center**  
**St. John's Mercy**  
**St. Louis Children's Hospital**  
**St. Louis University Medical Center**  
**St. Mary's Health Center**

### WISCONSIN

**Beloit**  
**Fond Du Lac**  
**Kenosha**  
**Monroe**  
**Waupun**

**Beloit Memorial Hospital**  
**St. Agnes Hospital**  
**Kenosha Memorial Hospital**  
**St. Clare Hospital of Monroe**  
**Waupun Memorial Hospital**

(11/31/92)



## Harnessing the hassle gang

There is probably no physician in the United States who has not heard of "the hassle factor," a term used to refer to regulations, paperwork and third parties who generally interfere between physician and patient in the name of lower cost, but better quality care.

The term "hassle factor" has caught on and so has the reality. Major, big-time hassle arrived with the new year. In order to comply with RBRVS, HCFA's new reimbursement system, physicians have been forced to adapt to sweeping changes in reimbursement coding in a very short time. Other new members of the hassle gang include CLIA, a new federal law and regulations that purport to ensure quality laboratory tests. An old enforcer, OSHA, returns to the scene with new regulations that are supposed to prevent transmission of infectious diseases in the health care setting.

Last year's hassle gang – the PRO, the National Practitioner Data Bank, the Office of the Inspector General – is still around. The senior, seasoned members of the hassle gang – the myriad of state regulators – are also very much alive.

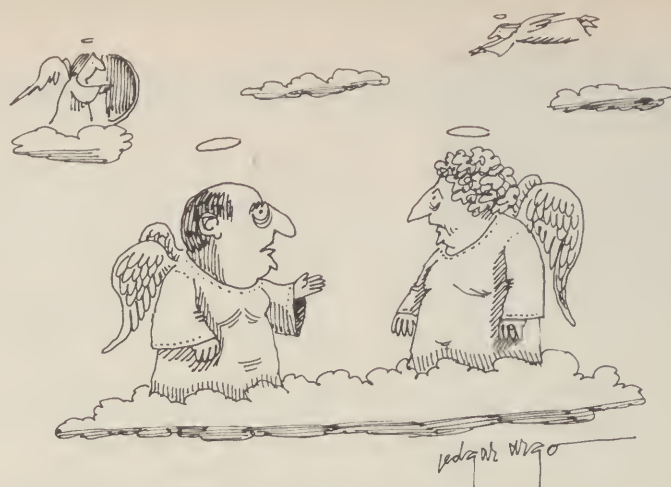
None of the hassle gang members set out to be one. They were recruited for what Congress and the Illinois General Assembly believed to be a good cause. But taken as a whole, the hassle gang is causing our neighborhood of physicians to look around for some serious relief.

That relief could come in the form of electing candidates who understand what we're going through. The primary is March 17. Do something for yourself, doctor. Take the initiative and find out who's running for Congress and the state legislature in your new district. Find out how they stand on major health care issues. Educate those who are receptive about how important it is for medicine to get some relief from hassle. Make sure candidates know that you are more concerned about your patients' welfare than your own.

There's another way to get some help. Mini-internships are being sponsored by county medical societies and auxiliaries in many places throughout Illinois. These events place public policy and opinion makers in medicine's shoes for a day. They expose the influential layperson to the life of a physician and show better than words the enormous satisfaction physicians derive from their calling. The mini-internships also illuminate – as no amount of hearing testimony ever could – the needless and often intransigent roadblocks that government regulation places in the physician's way. Volunteer to be a part of this project. If your county hasn't planned one, contact ISMS to request help to set one up. Physicians and laypeople alike who have participated in mini-internships have sung their praises as the best step they ever took to understand the other's problems.

Take two giant steps to help yourself find a hassle remedy: Vote March 17 for those who will listen to medicine and sign up for the mini-internship program sponsored by ISMS and the ISMS Auxiliary.

Sometimes, sharing problems can be a relief. If you would like to share through the pages of *Illinois Medicine* your firsthand account of what hassles you face in your medical practice, please write to Editor, *Illinois Medicine*, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602 or FAX us at (312) 782-2023. ▲



"I'm telling you for the last time, Mrs. Avery ... I'm no longer your doctor ... you're no longer my patient ... and your blood pressure no longer matters."

## President's Column

### The remap is only Round One

If it's true you can predict the future based on the past, the campaign and elections in Illinois in 1992 are going to be humdingers!

The remap process, recently decided by the Illinois Supreme Court, proved to be long, drawn out and more than a little acrimonious. That's to be expected. That a challenging and partisan debate accompanied the map(s) is no surprise. That the process itself has been challenged in editorial columns is also no surprise – drawing names out of a fishbowl puts some very important decisions at the hands of Lady Luck.

There is precious little time between now, the publication of the map of the new districts for the state General Assembly and the filing date, and the March 17 primary.

Candidates were not the only ones thrown into confusion by the remap process. We poor voters may be just as – if not more – confused. You may all of a sudden be living in a new district and the names you'll see on the ballot on St. Patrick's Day may or may not be familiar.

What's a voter to do? It's time for Civics 101 – and an important lesson that can be learned this year.

Some political writers have suggested that the Republican-drawn map presages a Republican majority in the Illinois Senate and a possible gain in seats in the House of Representatives.

Moreover, many analysts believe that a Republican Senate and stronger Republican presence in general in Springfield might improve the climate there for tort reform, especially since the governor is a tort reform advocate.

But unlike death and taxes – although the governor seems to be holding the line on taxes admirably – Republican gains are not a certainty. And tort reform has been, and can be, supported by candidates from both parties. So it is very important for physicians to go beyond party label to determine how a candidate stands on issues of importance to physicians.

Like the ads say, let your fingers do the walking – all over your telephone dial.

You'll soon be inundated with campaign literature from candidates



Robert M. Reardon, M.D.

seeking your support in the primary. Somewhere on every mailing, every flyer, every doorknob hanger, is a telephone number. Call it. Ask the volunteer who answers the phone for information on the candidate's position on health issues – on tort reform, on health care reform, on mandatory assignment, on any and all of the issues that are important to you as a doctor practicing in Illinois.

The chances are good that whoever answers the phone won't have the answers at his/her fingertips – and it may be that the candidate hasn't yet articulated a position on health care. Keep asking. And make it clear that your vote will go to the candidate whose position on these issues most closely matches yours.

Make 1992 your year in politics. Get involved in this very important campaign. Contribute to the candidate of your choice: Give freely of your time to a candidate; make a contribution to IMPAC, the Society's political action committee. The candidate who wins will remember, when he or she is settled in Springfield, and you'll have an important contact, perhaps for most of the coming decade. At the same time you can serve as an important resource, helping your elected representative understand the issues and the position of organized medicine on those issues.

Above all, make time to vote. The primary is just as important as the fall election, especially this year. This is our best chance in almost 15 years to make medicine's voice heard where it really counts – at the ballot box and in Springfield.

Robert M. Reardon, M.D.  
President

## Illinois Medicine

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## Guest Editorial

## Health care and the growing ethic of entitlement

by Stephen Chapman

When the Bush administration recently proposed a universal health card to provide patient information and simplify billing, *Washington Post* columnist Robert Kuttner waxed scornful. "It is very much like cards carried by Canadians, the British, Germans, Swedes and inhabitants of other civilized nations, with the one key difference that you're on your own when it comes to paying the bill," he wrote. "It is a bit like a credit card with no line of credit."

Imagine that. Americans who want health care will continue to be deprived of the option of consuming all they desire and sending the bill to someone else. They will actually be expected to pay (or arrange for an insurer to pay) for their treatment as if it were any other commodity. What could be more outrageous? Next thing you know we'll be expected to pay for our own food, shelter and clothing.

Kuttner is wrong in his thinking about health care, but he has plenty of company. When Americans complain about their medical system, they aren't unhappy with their doctors, the quality of treatment or the availability of services. More than 90 percent say they are personally satisfied with their care.

*"Neither mail nor medicine can really be delivered free — citizens pay directly in fees or indirectly in taxes."*

But thanks to Medicare, Medicaid, public hospitals, tax-subsidized employee health insurance and other government programs, Americans have gotten the idea that every person has a right to the best care at someone else's expense. If medical care is a right, it's deeply unjust to demand any financial sacrifice from its recipients. Here, the entitlement ethic has spread far and wide. Everyone wants to live at the expense of everyone else.

This desire is encouraged by the belief that people elsewhere have invented a way to do just that. Canada allows patients to choose their private doctors, but virtually all bills are paid, and all fees set, by the government. Its approach has reputedly given Canada both lower medical costs and better health than the United States. Canadians, unlike Americans, are also happy with their system.

But it's easy to see why it enjoys such popularity: It's practically free. The U.S. Postal Service may not work very well, but if you could send anything from a first-class letter to a truckload of furniture at no cost, you'd probably be content with it.

Neither mail nor medicine can re-

ally be delivered for free — citizens pay directly in fees or indirectly in taxes. But by separating the payment from the service, the government allows its constituents to think they're getting something for nothing.

Getting health care "free" distracts Canadians from disagreeable facts, such as these: Their health care costs have grown faster than ours in the last 20 years, people needing surgery generally have to endure long waits, and many forms of technology that Americans take for granted are pathetically scarce. If Canadians enjoy better health than Americans, it's largely due to causes unrelated to medicine, like lower rates of crime and poverty.

Letting Washington assume all responsibility for paying for every citizen's medical care is supposed to save us all huge sums in administrative costs by substituting a single payer for the hundreds that exist now. If you believe this, you'll believe that cars would be cheaper if only one manufacturer were allowed to sell them.

That's no stranger than thinking the demand for medical care won't soar once patients are freed from the burden of payment. If the government assured every American a new car every five years at public expense, the nation would soon find itself spending a lot more on automobiles.

Prescribing more government involvement as a cure is like asking the doctor who botched your appendectomy to handle your heart bypass. Economist Milton Friedman notes that since Medicare and Medicaid began in 1965, the average cost of a day in the hospital has risen eightfold. Yet the number of beds has dropped, and improvements in health have slowed.

By spending more on medical care, the government has caused us all to get less medical care. It has also rapidly driven up the cost of treatment, making it harder for anyone but the government to afford.

If Washington were to find a way to spend less — say, by requiring every household to buy private health insurance to cover major expenses — the demand for health care would fall, doctors and hospitals would be forced to reduce their prices and total expenditures on health care would decline. The efficiencies generated by competition would provide the same benefits to health care recipients that Japanese automakers have provided to American consumers.

But that approach would also force Americans to recognize that they can't have all the health care they want for nothing. Right now that delusion seems too inviting to resist. ▲

*Stephen Chapman is a columnist for the Chicago Tribune, where this column originally appeared. It is reprinted with permission.*



## LETTERS TO THE EDITOR

### GAO report supports universal health system

The Nov. 22 President's Column "Assignment: Washington, D.C." showed the interest and active participation in the debate about health care reform by Illinois State Medical Society President Robert M. Reardon, M.D. However, I disagree with Dr. Reardon's conclusion regarding Lesson No. 3, which reads: "And no matter how you cut it, increasing access means increasing costs."

This statement conflicts with the June 1991 Report of the U.S. General Accounting Office on "Canadian Health Insurance: Lessons for the United States." The executive summary of this 85-page document states that:

"If the universal coverage and single-payer features of the Canadian system were applied to the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are currently uninsured. There would be enough left over to permit a reduction, or possibly even the elimination of copayments and deductibles. ..."

This report offers the best estimate available; the conclusion should reassure those who fear that a sound health care program will increase costs. It is unfortunate that the GAO report has been swept under the rug, after brief mention in the daily press. It should not remain there. In-

stead, it should be studied by all interested in reforming our national health care system.

Paul Ravenna, M.D.  
Evanston

### How much do the lawyers get?

I am very interested in the news story in your Oct. 11, 1991, issue concerning the \$36.4 million awarded to a Hanna City couple on behalf of their son who suffers from cerebral palsy and mental retardation. One important statistic was omitted from your article, and I wonder if you can supply me with this information. How much of this exorbitant and obviously punitive award goes to the lawyer who represented the plaintiffs? I assume that he will charge a contingency fee, and it would be especially interesting to know whether he will continue to receive his percentage from future payments received over the years. ...

The size of the award suggests a multi-million-dollar legal fee, which will add to the cost of health care while contributing nothing to the quality or availability of medical and hospital services.

Dennis B. Dorsey, M.D.  
Boca Grande, Fla.

*Editor's Note: According to the Illinois State Medical Inter-Insurance Exchange, the plaintiff's attorneys' fees will be determined in accordance with the Illinois statutes governing medical malpractice costs. ISMS-supported tort reform legislation in 1985 succeeded in placing some limits on plaintiff attorneys' fees in malpractice cases. But no fees in this case will be determined until all appeals have been exhausted and the case is finally concluded. That could take several years.*

Illinois Medicine welcomes letters on topics of interest to our readers. Write us at Letters to the Editor, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602 or FAX (312) 782-1654. Letters of any length will be considered for publication, but we reserve the right to edit for space.



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# CASE in POINT

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin

## Case #1

**The event leading to a claim** – A 43-year-old female was admitted to a hospital for laparoscopy after ultrasound indicated the presence of a small lower abdominal mass. General anesthesia was administered and the patient was intubated. One hour into the procedure, during which a ruptured corpus ovarian cyst was found, her position was changed from deep Trendelenberg to supine. Her heart rate began dropping rapidly. The anesthesiologist stopped the anesthesia and gave 100 percent oxygen. Atropine and ephedrine were given and full resuscitation efforts were initiated, but the patient died.

**What went wrong?** – Several medical experts suggested that the patient's irreversible cardiac arrest was caused either by clot or an air or gas embolus. Autopsy ruled out a clot, but showed no evidence of an air embolus. However, the patient had been insufflated with CO<sub>2</sub> and any embolus probably would have been absorbed into her system prior to autopsy.

**The resulting claim** – The patient's family sued, alleging negligence in administering and monitoring anesthesia, failure to act in a timely fashion to resuscitate and wrongful death.

**The outcome of the claim** – The case was settled for more than \$1 million.

**Some points this case makes** – The laparoscopy involved introduction of carbon dioxide into the patient's peritoneal cavity. Pressure on the veins could have in turn pressured the carbon dioxide into the patient's venous system, perhaps in the area of the ruptured ovarian cyst. Henri S. Havdala, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange Risk Management Anesthesia Subcommittee, suggests taking these three steps to avoid similar circumstances:

- Properly monitor the patient, including use of a Doppler.
- Measure end-tidal CO<sub>2</sub> when insufflating a patient for laparoscopy.
- Consider using a central venous pressure catheter to "bleed out" possible air emboli.

## Case #2

**The event leading to a claim** – Following an automobile accident, a 29-year-old female was admitted to a

hospital with severe injuries to both legs. Over a period of weeks, several operations were performed on her legs. Following open reduction and internal fixation of the left femur, the patient's blood pressure dropped precipitously, she experienced pulmonary edema and cardiac failure occurred. Despite efforts to resuscitate her, she died.

**What went wrong?** – This patient was known to have heart disease, was being treated with digoxin and had experienced atrial flutter during her hospital stay. A pre-operative assessment, which included blood gases and a pulmonary scan, was performed. As a result, she was classified as a Class 2 surgical risk able to undergo further surgery. However, no digoxin level was taken. Post-mortem examination revealed bilateral pulmonary edema and pleural effusion, ventricular hypertrophy and acute congestion of liver and spleen. An acute infarct could not be confirmed or ruled out.

**The resulting claim** – The patient's family sued the surgeon, anesthesiologist and hospital for wrongful death, charging that the surgery should not have been performed, given the woman's cardiac status. The suit also alleged failure to use proper equipment and procedures during surgery, equipment that might have prevented the woman's death.

**The outcome of the case** – The surgeon was dropped from the case, the anesthesiologist settled for \$240,000 and the hospital settled for an undisclosed amount.

**Some points this case makes** – A thorough pre-operative assessment, including obtaining a digoxin level, should be performed when patients with known heart problems who are being medicated with digoxin are scheduled for surgery. Dr. Havdala also suggests that use of a Swan-Ganz catheter with an arterial line is appropriate for such patients.

## Case #3

**The events leading to a claim** – A 41-year-old male was given a general anesthetic before excision of a hydrocele. He had refused spinal anesthesia. Surgical nurses positioned his arms on boards away from his body and secured them midway between wrists and elbows with elastic bandages. After surgery, the patient complained of pain, numbness and tingling in his left arm, but several days passed before the surgeon splinted it. After discharge, the patient saw a neurologist who diagnosed nerve entrapment as a result of the arms being too tightly secured during surgery. Two surgical procedures to release the nerve were only partially successful. The patient continues to have pain, numbness and loss of mobility in his arm.

**What went wrong?** – Since the injury was not present prior to surgery, it apparently occurred during the surgery.

**The resulting claim** – The patient sued, alleging that the surgeon, anesthesiologist and hospital personnel caused permanent left ulnar neuropathy.

## Watch for your free Exchange benefit brochure



IN THE NEXT few weeks, all Illinois State Medical Inter-Insurance Exchange policyholders can expect good news in the mail – a brochure detailing the Exchange's new defendant reimbursement program. "A Cornerstone of Security: Defendant Reimbursement Coverage" reminds policyholders that defendant reimbursement coverage is free, available to all policyholders to emphasize the value the Exchange places on the physician's role in his or her own defense.

The Exchange understands that loss of practice time means loss of income. Since July 1991, the Exchange has compensated physician defendants \$500 a day for attending depositions and trials. The brochure outlines the limits, terms and conditions of defendant reimbursement coverage. So check the mail for your brochure – and if you are a defendant ask your professional liability analyst about your defendant reimbursement check. ▲

**The outcome of the claim** – The surgeon, arguing that it is the primary responsibility of the anesthesiologist to check the positioning of the patient's arms, was dropped from the case. The anesthesiologist and hospital settled separately for less than \$40,000.

**The points this case makes** – To minimize such neuropathy, Dr. Havdala offers these suggestions:

- Properly position and pad a patient's arms. Be sure to document this in the chart.
- Heed a patient's postoperative complaints. Follow up all complaints and request immediate consultation.

Dr. Havdala says it is extremely im-

portant that physicians communicate with one another during a surgical procedure involving administration of anesthesia.

"Ideally, the same anesthesiologist who will give the anesthetic should do the pre-operative assessment of the patient. When this is not possible, the anesthesiologist who does the assessment and the anesthesiologist who will give the anesthetic should communicate before surgery to discuss any medical problems that a patient may have so that they can be taken into consideration and proper precautions taken." ▲

Carol Brierly Golin is publisher of Medical Liability Monitor.

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## A few of the scheduled mini-internship participants



Left to right: Illinois' First Lady Brenda Edgar, U.S. Rep. Thomas W. Ewing (R-Pontiac), State Sen. John W. Mailland Jr. (R-Bloomington) and State Rep. John F. Dunn (D-Decatur) are a few of the legislators, mayors, hospital officials, media representatives and community leaders who will participate in the 1992 mini-internship program. Interns spend time with physicians to observe their work and better understand medical issues. The mini-internship program was piloted in 1991 by ISMS, the Auxiliary and six county medical societies and auxiliaries. Last year, 25 people participated in the program.

# Auxilians plan exciting year for mini-internship program

by Kathy Meyer

LOCAL, STATE AND federal officials are among those scheduled to don white physician's coats as medical interns for a day in what promises to be an exciting year for the mini-internship program.

Some 56 interns – including U.S. congressmen, state legislators, mayors and local hospital officials – are expected to participate in the mini-internship program coordinated through the Illinois State Medical Society, the Illinois State Medical So-

cety Auxiliary and nine county medical societies and auxiliaries. Among those expected to participate in the program during January and February are Illinois' First Lady Brenda Edgar; Gary LaPaille, chief of staff to the speaker of the Illinois House of Representatives and chairman of the Democratic Party in Illinois; and Illinois Department of Public Aid Director Philip Bradley. In addition, U.S. Reps. Richard J. Durbin (D-Springfield), Terry Bruce (D-Olney), and Jerry Costello (D-Granite City) will participate in the program.

"It's an educational program," said Pam Taylor, legislative chair of the Auxiliary. "Most people don't understand what physicians do or the problems they face daily. This program gives them an opportunity to see what physicians do all day long and the obstacles they encounter."

ISMS and the Auxiliary launched the mini-internship program in 1991. In cooperation with six county medical societies and auxiliaries, the program provided government officials and community leaders the opportunity to observe firsthand the complexities of the health care delivery system in the state of Illinois.

Interns are assigned to physicians who take them through a typical day's work, including hospital rounds, office visits and daily paperwork. Interns are encouraged to ask questions during the day and during a debriefing session following the internship.

Many of those scheduled to participate in this year's mini-internship program represent local, state and federal government. Among those



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## OSHA

(continued from page 1)

The minimum penalty for a willful violation is \$5,000.

By March 5, physicians – and all employers whose workers could come in contact with potentially infectious blood or body fluids – must have an exposure control plan in place. The written exposure control plan must include an analysis of the risks of exposure to each worker with a "reasonably anticipated exposure to blood or other potentially infectious materials in the performance of their [daily] tasks," according to the AMA video.

The written plan also must explain how employees will be protected from these potential exposures and what training they will receive to identify and minimize their risk. The plan should include a timetable for implementing the remaining requirements in the standard, and should address how exposure incidents will be handled.

By June 4, physician-employers must have begun the process of communicating the risks of exposure to their employees and should have established a training program for employees in risk reduction and universal precautions. Along with the training, physicians and their employees must adhere to the strict tenets of universal precautions for



## Coming soon to a practice near you ...

Following is a tentative list of 1992 interns by county:

**Adams County:** Durbin; State Sen. Laura Donahue (R-Quincy); State Rep. Art Tenhouse (R-Liberty); Judy Rossmiller, formerly Rep. Durbin's aide; J.T. Dozier, insurance agent; Lawton Faler, health benefits manager, Moorman Manufacturing; and John Spurrier, president, Quincy Chapter of the American Association of Retired Persons.

**Macon County:** Bruce and Durbin; State Sen. Penny L. Severns (D-Decatur); State Rep. John F. Dunn (D-Decatur); Merv Jacobs, county super-

visor; *Decatur Herald and Review* reporters Angela Callahan and Rick Manugian; Bob Ellison, Tate & Lyle; and Theresa Hicks, Archer Daniels Midland.

The **McDonough County Medical Society** is planning for three interns, including Macomb Mayor Tom Carper.

**McLean County:** U.S. Rep. Thomas W. Ewing (R-Pontiac); State Sen. John W. Maitland Jr. (R-Bloomington); State Rep. Gordon L. Ropp (R-Bloomington); Donald Engelkes, vice president, Country Life Insurance; and James Rutrough, vice president, personnel, State Farm Insur-

ance Co.

**Peoria County:** Ray LaHood, U.S. Rep. Robert H. Michel's chief of staff; Jerry Custer, benefits supervisor, Central Illinois Light Co.; Dave Kaehler, executive director, Peoria Area Labor Management Council; and nine hospital trustees from Methodist Medical Center, Proctor Hospital and St. Francis Medical Center.

**Rock Island County:** State Sen. Denny Jacobs (D-Moline); State Rep. Joel Brunsvold (D-Rock Island); Phil Hare, administrative assistant to U.S. Rep. Lane Evans (D-Moline); Carrie Dann, reporter, *Quad City Times*; and L. Boyd McIntire, American Association of Retired Persons representative.

**Sangamon County:** State Reps. Michael D. Curran (D-Springfield) and Karen Hasara (R-Springfield); Bradley; Mike Daley, Congressman Durbin's Springfield director; LaPaille; Brenda Edgar; and Felicia Norwood, the governor's executive assistant.

**St. Clair County:** Costello; State Rep. Wyvetter Younge (D-East St. Louis); Gordan Bush, mayor, East St. Louis; Roger Schlueter, reporter, *Belleville News-Democrat*; and Larry Johnson, reporter, *Belleville Journal*.

**Tazewell County:** State Reps. Jay R. Ackerman (R-Morton) and Thomas Homer (D-Canton) and State Sen. Robert A. Madigan (R-Lincoln). ▲

are 15 state legislators, three U.S. congressmen, two Illinois leadership staffers, three congressional staff members, two mayors and the director of IDPA.

The program is not intended to be a lobbying tool, Taylor said, but is a way to give legislators a better understanding of physicians' problems. "Education plus observation equals understanding," Taylor explained. "If they [legislators] understand the problems [physicians are faced with], they are better able to write good legislation."

Politicians will not be the only ones trading in their normal attire for surgeon's scrubs. Also scheduled to participate in the program are six members of the media, 10 hospital trustees and board members, and 17 business and community leaders.

These figures compare to the 25 interns who participated in last year's pilot program, which included one U.S. congressman, 11 state legislators, eight media members and five community leaders from local government and businesses.

Taylor attributes this year's strong participation to an increased number of counties implementing the program, the Auxilians' efforts in promoting the program and the success of last year's program.

In 1991, Adams, Macon, Peoria, Rock Island, Sangamon and St. Clair counties implemented the mini-internship program. This year, three more have joined the program — McDonough, McLean and Tazewell.

"This is the second year for the program, and the Auxilians feel more comfortable with the whole thing. During the first year, they were uncertain how physicians would react to interns and how interns would react to physicians," Taylor explained. "But everyone worked very well together. There wasn't one thing that went wrong."

"The overwhelming response from last year's interns was, 'You know physicians actually talk to patients,'" Taylor continued. "This is what we want them to see." ▲

all patients.

Physicians must provide employees with the protective equipment necessary for barrier techniques. This includes masks, gloves, safety goggles or glasses, face shields, fluid-resistant gowns or aprons, and protective foot coverings, if needed. The video recommends health care workers wear a mask whenever they are using eye protection to guard against splashing.

The OSHA rules prohibit workers from bending, breaking or recapping needles by hand unless the practice is unavoidable or is required by a specific medical procedure. If a needle must be recapped, the health care worker must use a mechanical recapper or a one-handed technique to avoid a stick injury.

Used needles must be discarded in impervious sharps containers, bearing the international biohazard symbol. The video recommends sharps not be left for "someone else to clean up," because such practices can increase the chance of injury. In addition, to facilitate disposal of used needles, sharps containers should be emptied frequently and conveniently placed in sites where needles and other sharps are used.

All medical waste — including bags of waste and sharps containers — must be properly sealed and labeled

according to the provisions of the law. State and local laws regulating the disposal of infectious medical waste also must be followed. (See related story, page 3.)

Finally, employers are required to provide the hepatitis B vaccine free to all employees who are exposed to blood or other body fluids. While the government recognizes it may be impossible to complete the entire three-shot regimen for all employees by the July 4 deadline, the law requires that the vaccination program be started by that time.

Employees are not required to have the vaccine. But employees who refuse vaccination must sign a waiver, which the physician-employer must retain for record-keeping purposes.

The AMA video will be televised on the Discovery Channel in February and March. The video also is available to physicians to help train office staff. Cost for the video is \$75. Physicians also can buy the AMA's OSHA bloodborne pathogen compliance kit, which includes the video, an administrator's guide and a training manual, giving physicians all the tools they need to bring their office into compliance. The kit is \$150 for AMA members and \$195 for non-members. To order a kit or video, call the AMA at 800-933-4AMT. ▲



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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

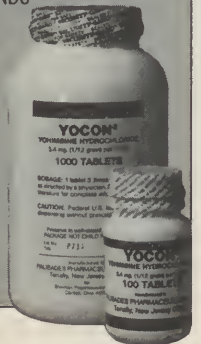
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Illinois Medicine asked several physician members of the Governor's Task Force on AIDS in Health Care:

## What can physicians do to allay public fears about contracting AIDS in health care settings?



**Jacek B. Franaszek, M.D.**  
Emergency physician, Hinsdale

Physicians can play two roles. One is to adhere to universal precautions themselves, as well as making certain all the people they work with adhere to them. Secondly, physicians can take an educational role, since each physician has the opportunity to contact several thousand patients. In some settings – for example mine, the emergency department – physicians come in contact with hundreds of thousands of patients. Each one of those encounters affords an opportunity for education. I think if we do that public fears will be allayed.



**Nestor Ramirez, M.D.**  
Task force chairman  
Pediatrician, Urbana

One of the best forms of education that a physician can always give is education by example. If a health care worker is careful and explains the procedures to a patient, uses preventive measures such as universal precautions and what they're using in hospitals now – the BSI, body substance isolation programs – that is one of the best educational opportunities. This method of teaching by example will give patients a way of analyzing their own behavior and using preventive measures also.



**Howard T. Strassner, M.D.**  
Obstetrician/gynecologist, Chicago

A major role that physicians in public health and others are going to have to play is providing adequate information to the public to give them a context as to what the actual risk is. Most of the information coming out is that there is really a very low risk of patients acquiring infection from health care workers. There is probably a lot of misinformation or lack of information about this, so a big role is going to be education.



**Cary F. Andras Jr., M.D.**  
Orthopedic surgeon, Jacksonville

Physicians have to assume the primary role of dispensing factual information. This is best done in a direct situation, face to face with the patient when it comes up, for whatever reason. We shouldn't shirk that duty, because we have a tremendous opportunity at that point to allay fear and dispense accurate information. ▲

Interviews by Anna Brown  
Photos by William Daniels/  
The Photo Partners

### Employee (continued from page 1)

Month award is a component of the new "Focus on Service" initiative, unveiled in September. The Exchange and its operating arm, Illinois State Medical Insurance Services Inc., are working in conjunction with ISMS to improve policyholder perceptions of the Exchange.

Lerner presented Moss with a recognition plaque and a check for \$200. In addition, Moss' name is displayed in the ISMS reception area on a special plaque listing service winners for the year.

Moss, who has been on staff for three years, is a senior professional liability analyst in the Exchange Claims Division. He was cited for consistent innovation and service that "the selection committee believed truly exemplify the qualities sought in any Employee of the Month," according to the selection committee's report.

"John is keenly aware of service to physicians," said ISMIS Secretary-Treasurer Donald Udstuen during the presentation. Udstuen cited Moss' role in integrating the Exchange data base into the word processing system, thus facilitating the department's ability to regularly update physicians with letters and status reports.

Udstuen also noted that Moss delayed his vacation over the 1991 Memorial Day weekend to conduct a physician interview, in order to accommodate the physician's schedule. "That's the kind of extra effort that goes into this selection," Udstuen said.



Left to right: ISMIS Secretary-Treasurer Donald Udstuen, ISMS/ISMIS Chief Executive Officer Alexander R. Lerner, Employee of the Month John Moss and ISMS Vice President of Internal Audit and Acting Vice President of Claims Jim Skinner celebrate after Moss' award ceremony Jan. 10.

stuen said.

Appointed to the Claims Data Committee in 1989, after only six months with the Exchange, Moss helped develop an automated diary system for the Claims Division, resulting in streamlined file deliveries to analysts each day. The system is being used as a prototype for a similar system for the Underwriting Division.

Moss was the overwhelming choice of his peers to represent the Claims Division on the Focus on Service steering committee, which oversees implementation of the new initiative.

"Someone out there must have nominated me for this and I just

want to say that I appreciate it very much," said Moss. "I've enjoyed the opportunity to attempt to serve your interests on the steering committee, and this will certainly make me redouble my efforts in that regard. I just want to say thank you very much for the support I felt this morning."

#### All employees eligible

While the Focus on Service initiative will improve service to members and policyholders, the Employee of the Month award recognizes both employees who deal directly with members and policyholders, and employees who support those efforts.

Employee of the Month criteria re-

quire that nominees exhibit innovation, creativity and problem solving, be team players who maximize results and, most important, provide extraordinary service to members, policyholders or internal staff. Recognition can result from either specific efforts on a single project or a consistently high level of performance and service.

Employees can be nominated by ISMS members or by fellow employees. Nominations that have been submitted thus far continue to be considered, but new nominations are encouraged.

"The current selection committee asks that nominations contain specific examples of how the nominee fulfills the criteria," said a representative of the ISMS human resources department, which administers the program. "It's better to err on the side of too much information instead of too little."

Any full-time, permanent ISMS employee is eligible for the award, except those at the senior management level. The confidential nominations are evaluated by a secret selection committee consisting of five randomly selected employees, including two ISMS/ISMIS vice presidents. Committee members serve six months, with one vice president and one other employee held over the next six months for continuity. ▲

*Editor's note: Physicians who wish to nominate a staff member for the Employee of the Month award should call the ISMS human resources department at (312) 782-1654.*



# Primary care is UIC Rockford focus

by Rachel Brown

PRIMARY CARE IS "Rockford's bag," says Bernard Salafsky, Ph.D., director of the University of Illinois at Chicago's College of Medicine at Rockford.

"There is a strong belief here in the need not only to inculcate primary care in every physician who gets trained, but also to do our best to promote primary care in view of what's needed today in this country."

By his own admission, Dr. Salafsky is somewhat of a "unique bird." As head of the UIC program at Rockford, Dr. Salafsky joins the ranks of only a handful of PhDs, as opposed to MDs, who head programs in U.S. medical schools.

Dr. Salafsky arrived in Rockford in 1977 as professor and head of the department of biomedical sciences. As director, a position he has held since 1983, Dr. Salafsky also serves as associate dean of the college and helped shape the Rockford program into one that focuses on what he believes is needed most in this country — primary care physicians.

Fifteen years ago the Rockford medical school developed a program to give students the opportunity to develop what Dr. Salafsky calls a "longitudinal exposure to medicine." By operating three community health centers in areas outside Rockford, the medical school allows its students to see the step-by-step progression of a developing disease, he says.

"Today, because of economics," Dr. Salafsky explains, "people are in hospitals for a very short time and much of the surgery is done on an outpatient basis. Where does the student get the longitudinal picture of a developing disease?"

All students are required to spend 2½ years in these centers, says Dr. Salafsky, so by the time they graduate, students have had contact with roughly 100 patients.

*"It is important that in this age of communication we create a global village. It is important for [students] to see what medicine is like outside of America."*

This clinic experience allows students to develop a "much closer relationship with patients and patient care and sensitizes them to those aspects of medicine. In a hospital, you don't have the chance to do that all the time," he adds.

The medical school program has the strong support of the three area hospitals as well as the rest of the medical community. "Almost every physician who comes to Rockford is interested in this program and in becoming affiliated with it," says Dr. Salafsky. For the 150 medical students in attendance at the Rockford campus, there are 450 part-time and 50 full-time faculty members.

The medical school faculty, led by Dr. Salafsky, recently began a social advocacy program geared toward teens in rural communities. Medical faculty visit local high schools to en-

courage students to explore career opportunities in medicine.

"It is really important to do this in some of these rural communities where we want to get young men and women interested in medicine," he says. "These are the people who will ultimately go back to those communities to practice medicine."

## A model for the world

Before coming to Rockford, Dr. Salafsky spent seven years working for the University of Pennsylvania and the World Health Organization, setting up and improving existing medical schools in Asia and the Middle East. His ties to the World Health Organization led to Rockford's participation in an interna-

tional exchange network with community-based schools in Third World countries. For the past three years, two fellowships have been offered annually to Rockford medical students, allowing them to travel and study at one of the participating network schools.

Through this international exchange, Dr. Salafsky says, Rockford's strong primary care focus acts as a model for other countries as well.

"Rockford [could serve] as a model for much of the medical education that is needed in the world," he says. "We don't have a lot of focus here on the subspecialties. We are training broad-based generalists in medicine. We emphasize primary

(continued on page 12)



Bernard Salafsky, Ph.D., director of the UIC College of Medicine at Rockford, says Rockford's program could serve "as a model for much of the medical education that is needed in the world."

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## Aurora surgicenter

(continued from page 2)

meeting the needs of the independent physician community so they can remain competitive in the Aurora health care market."

Copley decided against participating in the clinic, claiming a day surgicenter duplicates services already available. "There is no need for that type of facility in Aurora," Copley Vice President Al Aardsma told *Illinois Medicine*. "Rather than going to great expense to provide a duplicative service, we should work within the existing system to resolve any problems."

"Commercial, for-profit surgicenters skim the cream of the paying patients, leaving the underinsured and non-insured patients for the hospitals," Aardsma added. "It's the wrong

time [because] of the recession to consider adding an unnecessary service."

But Dr. Snyder said Dreyer plans to handle its fair share of underinsured patients. "We also will be taking care of our percentage of Medicare and Medicaid patients," he said, adding that the clinic's current payer mix includes about 25 percent to 27 percent government-covered patients. Dr. Snyder said Dreyer physicians "don't turn anyone away" and treat "some" non-insured patients.

### Dreyer MDs take OB deliveries to Mercy

Meanwhile, Dreyer's obstetricians have announced they will restrict their practice to Mercy as of July 1. Although Dreyer currently has five Ob/Gyns on staff, by May 1 that number will be reduced to three.

"We did not feel there was any way possible only three doctors could cover two hospitals; they're having trouble doing it now [with five]," Dr. Snyder said. "They are already considerably overworked and booked for about three months in advance."

Dreyer's five physicians currently split their approximately 1,500 yearly deliveries between Copley and Mercy. But the doctors made the decision to go with Mercy because when the surgicenter is up and running, they will be closer to Mercy, Dr. Snyder said. "We felt we might as well make the move to Mercy now," he added. "We've told Copley that when we can recruit more obstetricians – and we have been vigorously attempting to do that for several years – and we can get enough staff to cover both hospitals, we will go back to delivering at both. Right now it's a

physical impossibility."

Copley officials claim many area residents choose their hospital for deliveries. Dr. Snyder said he believes "patients will go where their physicians take them."

*"This is a community crisis and it will [take] a community solution. We're seeking productive dialogue among the physician, hospital and patient communities."*

"For years, the older doctors went only to Copley and the younger physicians went to both," he said. "But in the past few years, there has been a steady trend equaling them out, with probably a few more [deliveries] being done at Copley."

Copley's Aardsma said the decline in the number of obstetricians in Aurora is a chronic problem. He estimates only about 10 or 11 Ob/Gyns practice in the city and adds, "We definitely need a handful of additional OBs."

"This is a community crisis and it will [take] a community solution," he said. "We're seeking productive dialogue among the physician, hospital and patient communities." ▲

## UIC Rockford (continued from page 11)

care, and that's what the world needs.

"It is important that in this age of communication we create a global village. It is important for [students] to see what medicine is like outside of America," he adds.

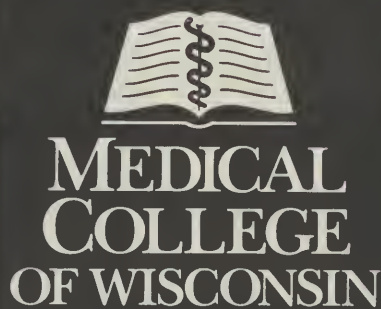
### Regional academic health science centers

The future of the Rockford program, according to Dr. Salafsky, is the development of a "regional academic health science center," including not only physicians, but also pharmacologists, nurses and social workers.

"There is still only one pharmacy school in the state," says Dr. Salafsky, who received his Ph.D. in pharmacology from the University of Washington in Seattle. "Pharmacy has been looking, as medicine looked 20 years ago, to the possibility of regionalizing its programs."

Already under way in Rockford is a new pharmacy program, allowing students to begin their pre-professional studies in Rockford, transfer to the University of Illinois College of Pharmacy in Chicago for their middle years and return to Rockford for their clinical practicum. In addition, Rockford now offers two master's degree programs in nursing and is working on the possibility of a master's of social work degree.

"Although medicine is at the core of [the regional academic health science center], by allowing the medical school faculty to work together with the nursing faculty and the social workers, these people in turn will be involved in the training of future physicians," says Dr. Salafsky. "That is the concept of this center, to work together." ▲



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The PATH PPO network includes 35 hospitals. Four of these are located outside the Chicago market in northwest Illinois and are not shown on this map. Yellow indicates Evangelical hospitals; green indicates the LGHCS-operated hospital.

## PPO (continued from page 1)

transaction.

"Managed care networks, which provide PPOs, ... HMOs, utilization review and other comprehensive services, will become increasingly attractive to employers as they intensify efforts to control corporate health use and costs," predicted Stephen L. Ummel, LGHCS president and CEO.

The purchase of Parkside is the second in a series of managed care ventures between Evangelical and LGHCS. Behavioral Health Direct, which offers self-insured employers direct contracting for behavioral

health and substance abuse treatment services, was launched in August 1991. That program will now fall under the umbrella of new cost-saving managed care programs the partnership plans to inaugurate.

"The PPO will continue to be a leading managed care vehicle to help employers control their health care costs," Risk said, adding that expansion will include a variety of PPOs, an EPO and other specialty products to fit niches created by Chicago-area employers.

"Over the next 18 to 24 months we are going to look very actively at establishing an HMO," Risk said. "We're not going to be comfortable

"Mandating a personal physician is almost like mandating testing."

While discounting the idea of requiring a personal physician for all health care workers, the group agreed to consider further the recommendation that impaired health care workers, including those who are HIV-positive, discuss their conditions with a personal physician. Members suggested this measure was in line with CDC and American Medical Association ethical guidelines requiring impaired physicians to review their health status and work with a local expert panel of physicians.

"This assures that these issues can be discussed in a confidential manner," said Dr. Dekker.

Education for health care workers was another major topic at the January meeting. Members noted that some states mandate basic HIV education courses for health care workers, while others require health care workers to take a certification exam.

"We felt such education on a voluntary basis may be a good idea," said Howard T. Strassner, M.D., chairman of the subcommittee on regulatory activities, during the meeting.

Also discussed was the possibility of recommending, as is being vigorously advocated by the AIDS activists who have attended each meeting, the repeal of S.B. 999.

"That has been mentioned as a possibility," said Dr. Ramirez. "We might recommend that the law should be changed or repealed," he said, stressing that the task force is closely examining all possible recommendations, and that repeal is one of the least likely. ▲

just staying in the PPO."

PATH PPO includes 2,800 physicians, 40 percent of whom specialize in primary care. Specialty providers include MRI centers, addiction treatment centers and ambulatory surgery centers. PATH plans to double the number of Chicago-area covered patients by 1994.

"Physician employees of PATH can anticipate a much-improved PPO," said Walter Hollinger, M.D., Parkside vice president of medical affairs. "It will be very comfortable from a clinical perspective."

Dr. Hollinger said Parkside is continuing to accept physician candidates, especially as the new programs expand. Specialists will be in demand for the planned niche PPOs, which could expand west of the Chicago area, depending on the

client base.

"Our goal is to make PATH's administrative procedures as effortless as possible for physicians," Dr. Hollinger said.

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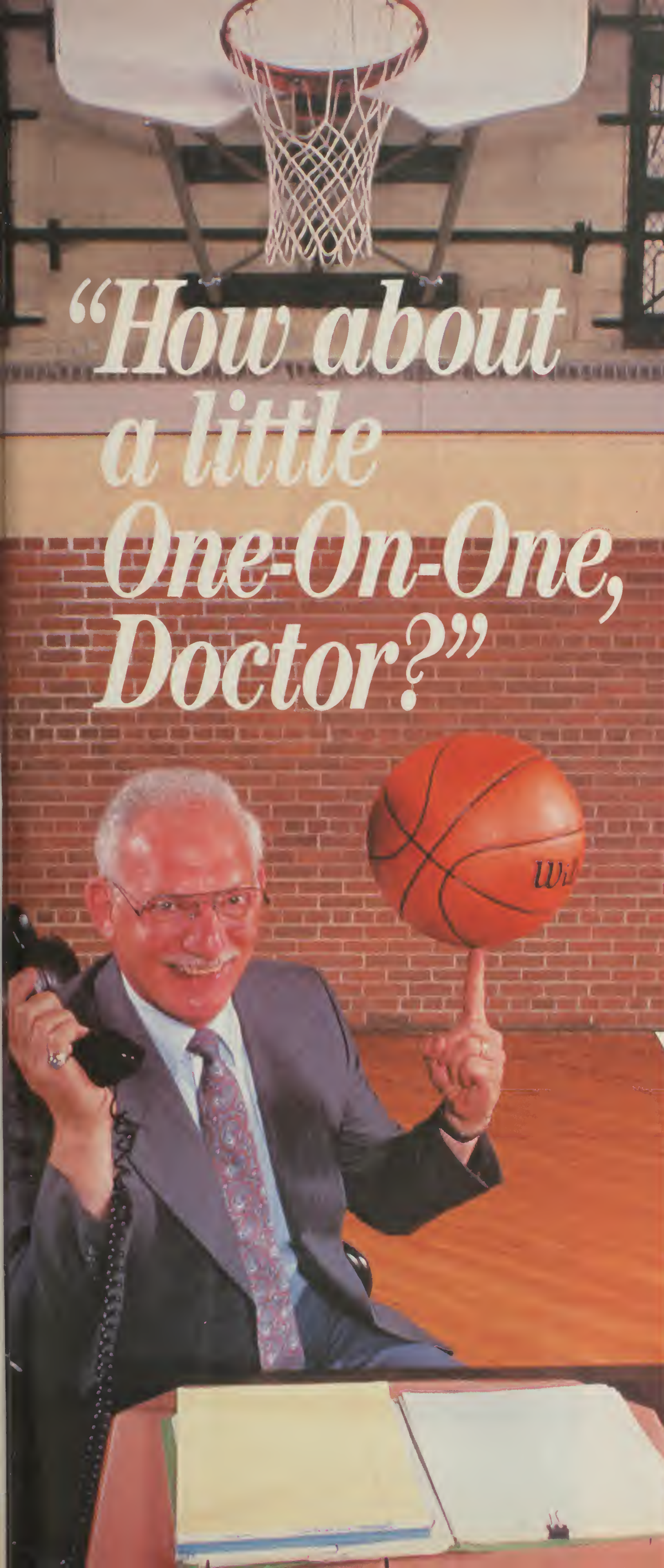
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#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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# Illinois Medicine

Utilization  
review issue

February 14, 1992

ILLINOIS STATE MEDICAL SOCIETY

## A reminder ...

The 1992 Illinois State Medical Society Annual Meeting April 10-12 has been moved to Oak Brook Hills Hotel in Oak Brook.



"You're early. The ISMS annual meeting isn't for another 2 million years."

## ISMS Board OKs new budget with no dues increase

by Kevin O'Brien

THE ILLINOIS State Medical Society's 1988 three-year dues plan became a five-year plan Jan. 5 when the ISMS Board of Trustees approved a 1992 budget that includes no proposed dues increase for 1993.

"1992 is the fourth straight year that we've been able to hold the line on member dues increases," said ISMS President Robert M. Reardon, M.D.

At the 1988 annual meeting, the ISMS House of Delegates adopted a \$78 dues increase effective Jan. 1, 1989. The increase was intended to fund the Society's activities for three years: 1989, 1990 and 1991. An additional dues increase was anticipated at the 1991 an-

(continued on page 13)

## HHS: MDs required to provide new child vaccination warnings

by Rachel Brown

BEGINNING APRIL 15, all health care providers administering certain vaccines must provide written information about the diseases the vaccines prevent against, as well as possible adverse reactions to those vaccines.

The new rules, developed by the U.S. Department of Health and Human Services, are designed to help parents determine the benefits and potential risks of the three most common childhood vaccinations: diphtheria-pertussis-tetanus (DPT); measles, mumps and rubella (MMR); and polio, according to the U.S. Centers for Disease Control.

For more information,  
contact IDPH at  
(217) 785-1455

The CDC has developed three eight-page vaccine information brochures to be distributed to parents or guardians when vaccines are administered. According to the Illinois Department of Public Health, parents and guardians are required to certify that they have been informed of the benefits and risks of each vaccination. Each brochure contains a form indicating this consent.

Although the chances of vaccine-related injuries are remote, Jay Berkelhamer, M.D., president-elect of the Illinois chapter of the American Academy of Pediatrics, said the importance of parent

(continued on page 13)



HCC President and Chief Executive Officer Johanna Lund.

## A day on the job with an Illinois UR firm

by Anna Brown

A PREGNANT woman, due to deliver in a week, is admitted to the hospital in the afternoon and released that evening, but there is no indication a birth took place. The reviewer must find out what happened - perhaps false labor - and see if the hospital admission can be modified to an outpatient visit, which would not need to be reviewed.

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by Tamara Strom

PERHAPS NOTHING these days ignites fire in the eyes of physicians like a third party looking over their shoulder to determine if the care provided was appropriate. Like it or not, nearly every day physicians in Illinois and around the nation endure some kind of "utilization review," usually by the third parties who pay for their patients' health care.

As health care costs skyrocketed during the past decade, businesses, insurance companies and the government tried to rein in costs by reviewing the care for which they foot the bill. Integral to this review, payers claim, is a commitment to ensure that patients get the best possible care.

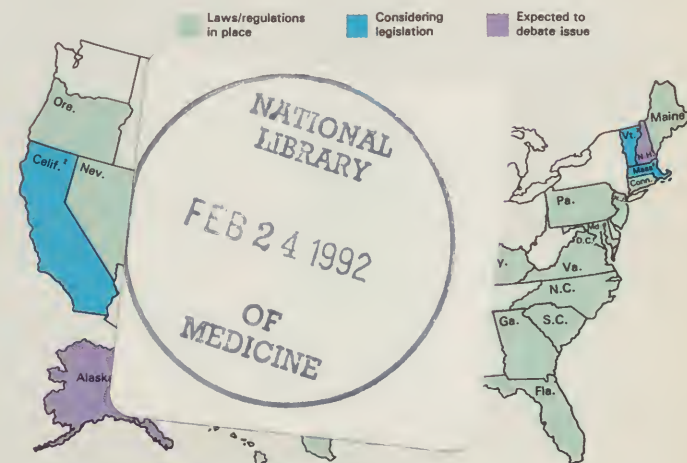
While controlling costs and assuring quality care are noble goals, the implementation of utilization review programs in the United States has not moved in a direction most physicians have liked. Many doctors contend that review adds unnecessary hassle and cuts into the time they spend with their patients.

"The basic personality of physicians in general is such that they take pride in what they do," said Richard A. Schmidt, M.D., an Ottawa family physician and chairman of the Illinois State Medical Society Council on Economics. "To get where they are they have undertaken intensive education, a strict licensing requirement; and have proven themselves. They are assumed to be

(continued on page

## Regulating utilization review

Utilization review laws generally address reviewers' qualifications, disclosure of review criteria and procedures and appeal processes. For details of Illinois efforts under way to regulate utilization review, see page 3.



<sup>1</sup>Laws relate specifically to review of claims involving mental illness or drug and alcohol abuse. <sup>2</sup>Measures introduced in 1991; legislatures meet year-round. <sup>3</sup>Bills are being held over until the 1992 session.

Source: Intergovernmental Health Policy Project, Washington, D.C.

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# ISMS addresses MD concerns about regulating UR

by Tamara Strom

DEALING WITH utilization review can make a physician feel like a quarterback who makes a game-winning throw in the big game only to have it called back for a penalty not spelled out in any rulebook. Efforts now under way in Illinois to regulate independent review organizations will assure physicians are not left in the dark about the rules or criteria UR firms use in reviewing care.

"There is increasing interest and willingness to come up with a mutually agreeable set of regulations," said John F. Schneider, M.D., Illinois State Medical Society Third District Trustee and immediate past chairman of the ISMS Council on Economics. "One question about regulation is, 'Do you let physicians know the criteria or rules of the game up front, or are the criteria [for standards of care] proprietary information, as many review organizations claim?'"

"A common claim of review firms is that if physicians knew the criteria, they would 'game the system,'" Dr. Schneider said. "But the other side is that if doctors knew the criteria, they would be better able to meet them."

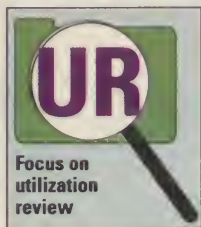
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*"A common claim of review firms is that if physicians knew the criteria, they would 'game the system.' But the other side is that if doctors knew the criteria, they would be better able to meet them."*

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Although physicians, third party payers and to a limited extent even the reviewing entities themselves agree some kind of regulatory oversight is necessary, no consensus yet exists about how extensive the regulation should be. For the most part, however, Illinois physicians are firm in their belief that something must be done – and quickly – to address their concerns about the current utilization review process.

At the direction of the House of Delegates, the ISMS Board of Trustees considered and recently adopted policy supporting regulation of utilization review through legislative action, said Richard A. Schmidt, M.D., chairman of the ISMS Council on Economics. Dr. Schmidt explained that the council had studied how best to regulate utilization review and has forwarded its recommendations to the Governmental Affairs Council. In addition, the Society has been communicating with the governor's office and the Illinois Department of Insurance to share physicians' perspectives on the



failings of current utilization review, and the merits of regulating the industry.

The council's suggestions provide a "desirable direction" in terms of regulating the review process, Dr. Schmidt explained. If adopted as regulations, the recommendations should ease some physician concern and uncertainty about utilization review, he said.

Specifically, the council advocates the following:

- Through regulatory mandate, all review agencies would be required to

register with the state. Some "fee component" would be included in the registration process, Dr. Schmidt said, which in turn would fund the state's regulatory efforts.

- After registering, review firms would be catalogued by a unique ID number. Dr. Schmidt said he hopes the state would issue a directory of registered firms, allowing physicians an easy way to check the identity of a reviewer calling for information about a patient. A frequent physician complaint about the current system is that doctors have no way to assure patient confidentiality when tele-

phone callers identify themselves as reviewers and ask for patient information.

"Most reputable firms have confidentiality built into their system," Dr. Schmidt said. "But if I'm responding to a voice over the phone, I don't know if it's really a reviewer or a family member seeking information or an attorney seeking information surreptitiously."

Dr. Schmidt explained that official ISMS policy opposes telephone review because of confidentiality concerns and the frequent interruptions phone calls cause to patient care. And although many physicians, including himself, would prefer a standard mail review form to telephone conversations, Dr. Schmidt said registering firms by state ID numbers

(continued on page 12)

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# REPORT

## FOR *Illinois Physicians*

### PAYMENT POLICIES CHANGE FOR MULTIPLE SURGERIES

Certain changes take place in Medicare payment starting in 1992 when multiple surgical procedures are performed on a patient on the same day. For example, if three or more separate procedures are performed, the approved charge for the third through the fifth highest valued procedures is the lower of the billed amount or 25 percent of the fee schedule amount for the procedure. Each procedure after the fifth procedure requires submission of documentation and special carrier review to determine the payment amount.

The policy for paying the highest valued and second highest valued procedures is unchanged. The approved charge for the first procedure is the lower of the billed amount or the full fee schedule amount. The rate for the second procedure is the lower of the billed amount or 50 percent of the fee schedule amount.

Another change is that surgery by podiatrists is subject to the multiple procedure reduction even when the procedures are performed on separate feet.

Certain dermatology CPT procedure codes indicate that multiple procedures were performed (for example, 11201, 17001, and 17002). Payment for such codes is not reduced by the multiple procedure rule described above. Each such code is assigned relative value units (RVUs) to account for multiple procedures. However, for other dermatology procedures, a 50 percent reduction for the second procedure is made. Payment for the third and any additional separate procedures requires an operative report and carrier review to determine the amount.

A considerable change occurs with regard to paying multiple but separate endoscopic procedures performed on the same body part on the same day. The approved charge for the highest valued endoscopy is the lower of the submitted charge or the full fee schedule amount. However, the approved charge for the next highest valued procedure is the fee schedule amount for that procedure minus the fee schedule amount for the basic endoscopy. For example, if the second highest valued endoscopic procedure has a fee schedule amount of \$400 and the basic endoscopy is valued at \$300, the approved charge for the second procedure is \$100. This rule prevents double payment for the basic endoscopy, which is included in each of the higher valued codes. Generally, the basic endoscopy is the first code listed within a family of endoscopic codes.

Furthermore, when endoscopies are performed in addition to a higher valued surgery, payment is subject to the general 100-50-25 percent multiple surgery reduction. Therefore, the approved charge for the endoscopy when performed with a higher valued surgery is the lower of the submitted charge or 50 percent of the fee schedule amount. In this situation, a second endoscopy is paid at 25 percent of the difference between the fee schedule for that procedure and the basic endoscopy.

Non-participating physicians not accepting assignment on multiple surgery charges are reminded that the limiting charge applies to the initial and each of the separate additional procedures. The additional procedures have a limiting charge in 1992 based on 120 percent of the reduced approved amount. The limiting charge and the multiple surgery payment policies need to be taken into account, particularly when charge data is disclosed to beneficiaries prior to elective surgery costing \$500 or more if assignment will not be accepted. Fee schedule amounts and limiting charges can be obtained from the Provider Hotline or from the Freedom of Information Unit. Also, multiple procedures should be included on the same claim. If separate claims are submitted, a recovery will be required if the claim for a subsequent procedure was processed first without the necessary reduction.

(2/14/92)



## Editorial

## If not now, when?

**W**ho should be thinking about living wills and durable powers of attorney for health care? You should, for one. Members of the Society will receive with this issue of *Illinois Medicine* a copy of a new information kit "A Physician's Guide to Advance Directives." This comprehensive guide to Illinois law regarding patient self-determination and advance directives should be "must" reading for every doctor in the state.

And after you've read it, you should carry it with you for a week or two to remind you to discuss these important issues with your patients. Because end-of-life decisions are best discussed long before they are needed. Senior patients are already contemplating their mortality and will probably appreciate your offering them a chance to discuss these options.

Patients who know the end of their lives are approaching as a result of disease may also welcome a quiet conversation reviewing options and talking about how they want that time handled. Including members of the patient's family in these talks can help ease the pain of a difficult time.

But there is a whole group of patients who probably should be thinking about advance directives that we may be forgetting. Let's call them "The Young and the Healthy." Less likely to succumb to disease, they are at risk of death by trauma and shock from everything from automobile accidents to plane crashes. These patients often have young children at home whose futures have been carefully considered in case the unthinkable happens.

Can your young and healthy patients afford not to think about the possibility that today's technology could keep them alive far into their children's adulthood, impoverishing their families?

The most important thing any advance directive will do is encourage conversation – with your patients, with your family, with your staff. Read the material and think about it. Sign your own living will – and tell your patients that you've done so.

Studies have shown that people want their physicians to talk to them about end-of-life decisions, but many patients don't bring the topic up, hoping the doctor will. The Society has distributed almost half a million copies of its patient brochure to the public, to hospitals and to nursing homes, to help patients make important end-of-life decisions. A recent request for 500 copies came from – a law firm. A review of the request list shows an interesting number of lawyers requesting the brochure for use during client discussions about estate planning. Shouldn't it be doctors talking to people about this? And if not now, when?

## Don't do it

**H**ere's a tempting offer you should turn down: HCFA's extension of the grace period to use the old Medicare codes. You now have until Feb. 29 to use the old codes, but it's not worth it. First, you're just putting off the inevitable: Sooner or later you and your staff are going to have to go through the agony of learning the new codes. No, it's not going to be easy and no, it's not going to be fun, but you're going to have to do it. You might as well do it now (clean your room, eat your broccoli, learn the new CPT codes) and get it over with.

Secondly, you could be losing money if you delay using the new codes. Reimbursement made under old codes will be made at old rates.

Get the new codebook, make the time to read it and schedule time for an effective learning session with your billing staff. Don't put off 'til tomorrow what you could learn today. ▲

## Illinois Medicine

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"M.D. used to stand for medical doctor. Now it stands for Medicare documentation."

## Guest Editorial

## Know what's on the back of your driver's license, too



by George H. Ryan

The information on the back of Illinois driver's licenses is becoming almost as important as the information on the front. For several years, Illinois residents have had the power to give life to others by signing the organ donor notification on the back of the driver's license or state identification card.

Now, with last session's passage of H.B. 1446, motorists can indicate that they have executed a durable power of attorney for health care or a living will. This information could prove crucial for emergency medical and hospital personnel in the event an injured patient is unable to communicate with the people providing medical care.

Unfortunately, many people do not understand or are frightened by the thought of organ donation, and most Illinois residents are unaware of the new advance directive provisions. As secretary of state, I am strongly committed to raising public awareness and understanding of this serious issue.

Nationally, about 23,000 people are listed as waiting for organ transplantation. More than 1,000 are on waiting lists in Illinois. While much has been written about the success stories and miracles of organ donation, many people do not know the agony and pain of those waiting for a second chance at life. Without

needed resources, human organs and tissue, medical technology means nothing.

Each year, more than 2 million people visit driver's license facilities in Illinois. Each of them is a potential organ donor. We have developed and implemented new training procedures to teach our employees about the importance of organ donation. Our personnel point out the organ donor section on the back of a driver's license or ID card, provide information, and encourage people to ask family members to sign as witnesses. In addition, a brochure about organ donation is mailed in every driver's license renewal notice. By making organ donation a priority, we hope the critical shortage of lifesaving donors can be greatly reduced.

But the fact an organ donor card is signed does not guarantee that the holder will be an organ donor: Consent is still required from the next of kin. For that reason, we must work together to ensure the public understands organ donation and the importance of communicating their wishes with their families. As medical professionals, you are often called on to provide this information to family members during a very traumatic time. A recent study has shown that family consent for organ donation has increased in areas where doctors and medical personnel are trained in ways to seek such permission. According to the study, timing and methods of approach are the most important factors.

Similarly, Illinois physicians are in an ideal position to provide accurate and necessary information regarding patient's rights under the Illinois Durable Power of Attorney for Health Care Act and the Illinois Living Will Act. By working together, we can increase public and professional awareness of these important matters. Whether working with other medical professionals to develop more effective ways to communicate with grieving family members or dispelling myths about organ donation, education is the key to saving lives. ▲

Mr. Ryan is the secretary of state for Illinois.



## Guest Editorial

## Utilization review

## The more they say it isn't the money – it's the money



by Arvind K. Goyal, M.D.

The neighborhood children were playing outside when a fire truck zoomed past. Sitting on the front seat was the familiar black and white Dalmatian. The children wondered what purpose a dog would have at a fire. "They use him to keep the crowd back," a six-year-old guessed. "No," said another, "they take him for good luck." A seven-year-old brought the argument to an abrupt end. "They use the dog to find the fireplug."

Many physicians have similar trouble understanding the cost and benefits of utilization review activities.

*"In our zeal to increase professional accountability and documentation, we physicians have unknowingly agreed to play by some unacceptable rules."*

In our zeal to increase professional accountability and documentation, we physicians have unknowingly agreed to play by some unacceptable rules, unilaterally established by parties other than physicians and their patients. How can pre-authorization of a given service such as hospitalization, surgery or other procedure by a less-qualified (or totally unqualified) "strange" reviewer at the other end of a telephone improve the quality of medical services? How can a call or a "denial of payment letter" to the treating physician or hospital's business office every day or two improve the efficiency of services to a hospitalized patient? Many entrepreneurial utilization review companies have successfully developed and perpetuated such practices under the pretext of quality and accountability. The UR industry claims to save \$3 for every dollar spent on review. It is no coincidence that while needed hospitals close, established physician practices go under,

public programs move toward insolvency, and access and cost of health care are under fire in the media and halls of Congress, the stocks of many of these prize-winning UR companies are skyrocketing. The more they say it isn't the money, it's the money.

It is clear that medical peer review or utilization review conducted by and on behalf of third parties has increased in recent years. About 600 organizations (corporations and departments within existing corporations of insurance companies and employers) have been formed nationwide to perform such activities. The criticisms, decisions and suggestions made by physicians or other employees on behalf of such organizations could have a substantial effect on the quality of patient care. Their decisions, when contrary to the care provided or planned by treating physicians, have the potential of discouraging patients from following the course of recommended treatment. There is a burden of liability placed on treating physicians because of disclaimers and decisions rendered by these reviewers.

And then there are issues related to the release of confidential patient information over the telephone: The true identity of the caller; serious potential ethical and legal problems; threatening and harassing language implying non-coverage for covered and contracted services when reviewers call physicians and, at times, hospitalized patients and their families; potential inadequacy and inaccuracy of review by phone without actual hospital record review; and finally, placing the physician-patient relationship in jeopardy.

An Institute of Medicine study committee recently found questionable cost benefits from utilization management but potential damage to quality of care and an emerging trend toward denial of care.

Several of these concerns have been addressed by resolutions adopted by the Illinois State Medical Society House of Delegates in recent years. In Illinois, the office of the governor recently directed the Department of Insurance to convene a discussion group for consideration of potential strategies in dealing with UR issues. The ISMS has already provided its concerns and comments on your behalf.

The current *non*-system of utilization review or medical peer review conducted by and on behalf of insurance companies may not be all wrong. Even a clock that has stopped running is right twice a day. The utilization review companies are not against physicians or patients. They're merely for themselves. ▲

*Dr. Goyal, ISMS president-elect, is a family physician from Rolling Meadows. This is an updated and edited version of an article that appeared previously in Chicago Medicine.*



"Stay away from women. The strings of your heart can't take any more zings"

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

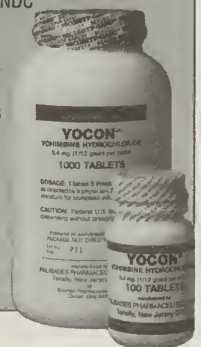
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
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Defense attorneys limited in ability to control their impact

# 'Day in the life' videos can unfairly overwhelm a jury

by Anna Brown

THE COURT testimony of a severely disabled plaintiff can make a significant impact on a jury in a malpractice liability case. But even the most vivid description of a plaintiff's difficulties in his or her daily routine may not pack the emotional wallop that a videotape showing those difficulties can.

And with the advent of easy-to-use video recording equipment, a plaintiff does not even have to testify. Instead, juries are shown "day in the life" videos.

Such videos can graphically depict a plaintiff's problems allegedly derived from malpractice injury. And while the videos do not fix blame, they can and do lead juries to maximize damages against defendants. Unfortunately, medical malpractice defense attorneys are severely limited in their ability to influence the effect such videos have on a jury.

A fall 1991 Illinois Supreme Court decision effectively denied defense attorneys access to the production of "day in the life" videos. In *Cisarik vs. Palos Community Hospital*, a malpractice case involving a brain-damaged child, defense attorneys petitioned the court for advance notice of filming, permission to be present during filming, the right to ask questions

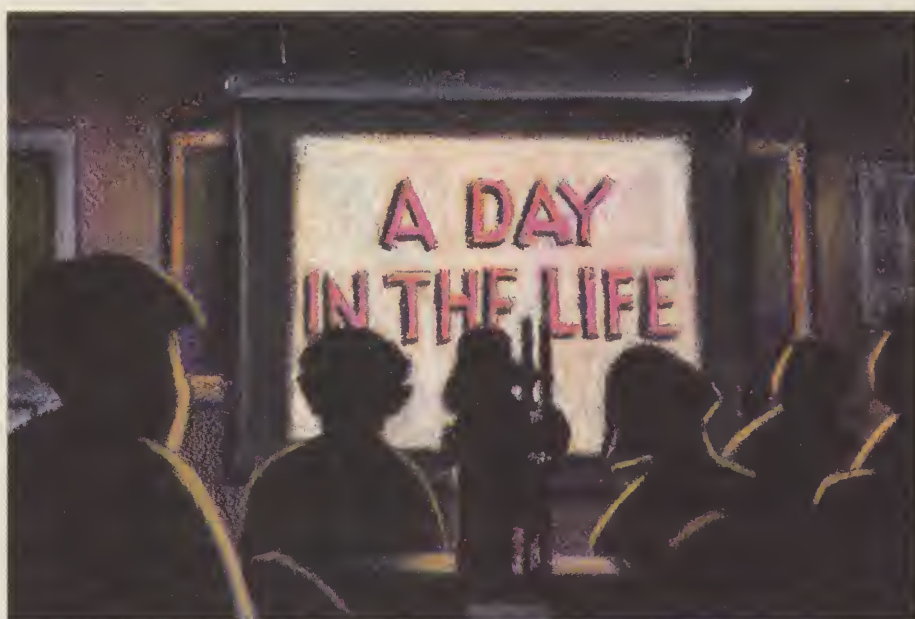


Illustration: Joe Hindley

and to have access to the uncut videotape. After a lengthy appeals process, the Supreme Court denied the requests.

Consequently, plaintiff attorneys can exercise wide latitude in a video's production. This leaves the door open for them to unduly manipulate a jury's sympathy.

"It has never been the Exchange's position to prohibit the use of truthful information in a trial," says Harold L. Jensen, M.D., chairman of the Illinois State Medical Inter-Insur-

ance Exchange Board of Governors. "However, the Exchange has long agreed with defense counsel who contend that showing 'day in the life' videos in court is inappropriate, since these tapes are so charged with emotion they can overwhelm a jury."

## Narrow purpose

There is no other purpose for "day in the life" videos, says Saul J. Morse, Illinois State Medical Society legal counsel, than to convince a jury that it should award high damages.

"What 'day in the life' videos add to the litigation process is a graphic demonstration of the difficulties an individual faces in life," Morse told *Illinois Medicine*. "They say to a jury, 'Look how different this person's life is.' This is much more vivid and descriptive than having someone say it in court."

*"Often the videos show what a person cannot do, not what they can. By showing the jury small snippets, the videos can make things look worse than they are. They don't show that the person still has a job, a home and relationships."*

"The nature of the movies is to show the plaintiff in an emotional light – to show overwhelming hardship," agrees E. Michael Kelly of Hinshaw, Culbertson, Moelmann, Hoban & Fuller, a defense attorney often retained by the Exchange and who represented Palos Community Hospital in the *Cisarik* case. He says that when a videotape is presented to the jury, a jury's "immense emotional response tips the scale."

He says some videos are so graphic that some jurors who indicated they would have been able to return a

verdict for the defense had nightmares after screenings and asked to be dismissed from the case.

Morse says that "day in the life" videos also "only paint half a picture. What these videos can take away from the process is the sense of permitting an exchange of information, with the ability of the defense to cross-examine."

"Often the videos show what a person cannot do, not what they can. By showing the jury small snippets, the videos can make things look worse than they are. They don't show that the person still has a job, a home and relationships, for instance," says Morse.

"Defense attorneys need to have the opportunity to say that while the injury is serious, it may not be as serious as the film leads you to believe," adds Kelly. "Juries have never been exposed to this kind of emotion before."

## Simple home video to professional production

"Day in the life" videos range from simple home videos to professionally produced motion pictures. The videos can feature daily activities of permanently disabled individuals performing tasks such as using a wheel chair, dressing, bathing and using the bathroom. Any assistance that is needed becomes especially evident in the videos, which can also portray the need for special equipment and physical modifications to a plaintiff's home.

According to Kelly, the plaintiff's attorney can shoot the video any way he or she wishes, but having a defense attorney present would help make the process "at least marginally fair" to the defendant.

"Allowing defense attorneys to be present would guarantee that the tape is honest," says Morse.

Defense attorneys liken the taping of "day in the life" videos to the taking of an evidence deposition, which is a substitute for the appearance of the witness at the trial. When such depositions are taken, defense attorneys are allowed to cross-examine the individual. The court, however, found "day in the life" videos to be in the same category of evidence as still photographs.

Kelly rejects this finding, charging there is "no similarity between the two because of the emotional load of the videos." He also disputes the contention that defense attorneys cannot participate in the filming unobtrusively, as the court stated. He compared the video shoots to the testing of products where counsel for both sides are allowed to be present. "The specter of a defense attorney intruding in the process is nonsense," he says.

Kelly believes the issue of defense participation will continue to resurface if abuses occur, such as cases where original footage is destroyed.

"These videotapes are so prejudicial and incredibly powerful," says Kelly, who never watches the tapes himself. "If I did watch, I couldn't deal with the case." ▲

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ISMS president to address IAO legislative dinner

EDUCATING legislators, regulators and voters about what ophthalmology is and what ophthalmologists do will be the topic of Illinois State Medical Society President Robert M. Reardon, M.D., when he addresses the Illinois Association of Ophthalmology's annual legislative dinner Feb. 21.

Dr. Reardon, an ophthalmologist and a founding member of the association, will



Froncie A. Gutman, M.D., president of the American Academy of Ophthalmology, will also speak at the dinner.

share the platform with Froncie A. Gutman, M.D., president of the American Academy of Ophthalmology. Dr. Gutman will speak on the academy's plans and objectives for 1992.

"The issues of optometrists being permitted to prescribe therapeutic drugs and the continuing importance of further tort reform are of vital importance to ophthalmologists and to all physicians," said

Dr. Reardon. "I hope to convey to my colleagues the need for their personal involvement in the political process, especially since redistricting offers us the best chance in years to accomplish many of our legislative goals."

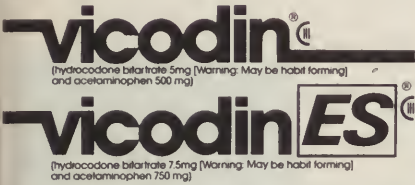
This year's dinner – which traditionally draws up to 300 people, including 20 to 25 legislators – will begin at 6 p.m. at the Oak Brook Hyatt Hotel in Oak Brook. Entertainment will be provided by the Second City Touring Company. The event is open to all ophthalmologists and their spouses. For ticket information, call the IAO at (312) 263-7150. ▲



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The Physician HELpline is a confidential, physician-directed advocacy service linking mentally or physically impaired physicians and their families with helpful resources. Call the 24-hour Physician HELpline when someone you know needs help. ▲



**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Usage in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Urteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit





# How to respond to a PRO quality inquiry

(Editor's note: The following is excerpted from the American Medical Association brochure PROs, written by the AMA's Department of Health Care Review and Carrier Relations and reprinted with permission of the AMA.)

Illinois physicians are reminded that specific PRO procedures may vary from state to state. The following information, while applicable nationally, may not reflect exact Illinois PRO protocols.)



UTILIZATION and quality control peer review organizations, commonly known as PROs, continue to implement "The Third Scope of Work," i.e., the third round of PRO contracts negotiated between the U.S. Health Care Financing Administration and the nation's 54 PROs. Effective April 1, 1989,

all PROs were bound by the new Scope of Work. Despite new contractual provisions in the Third Scope of

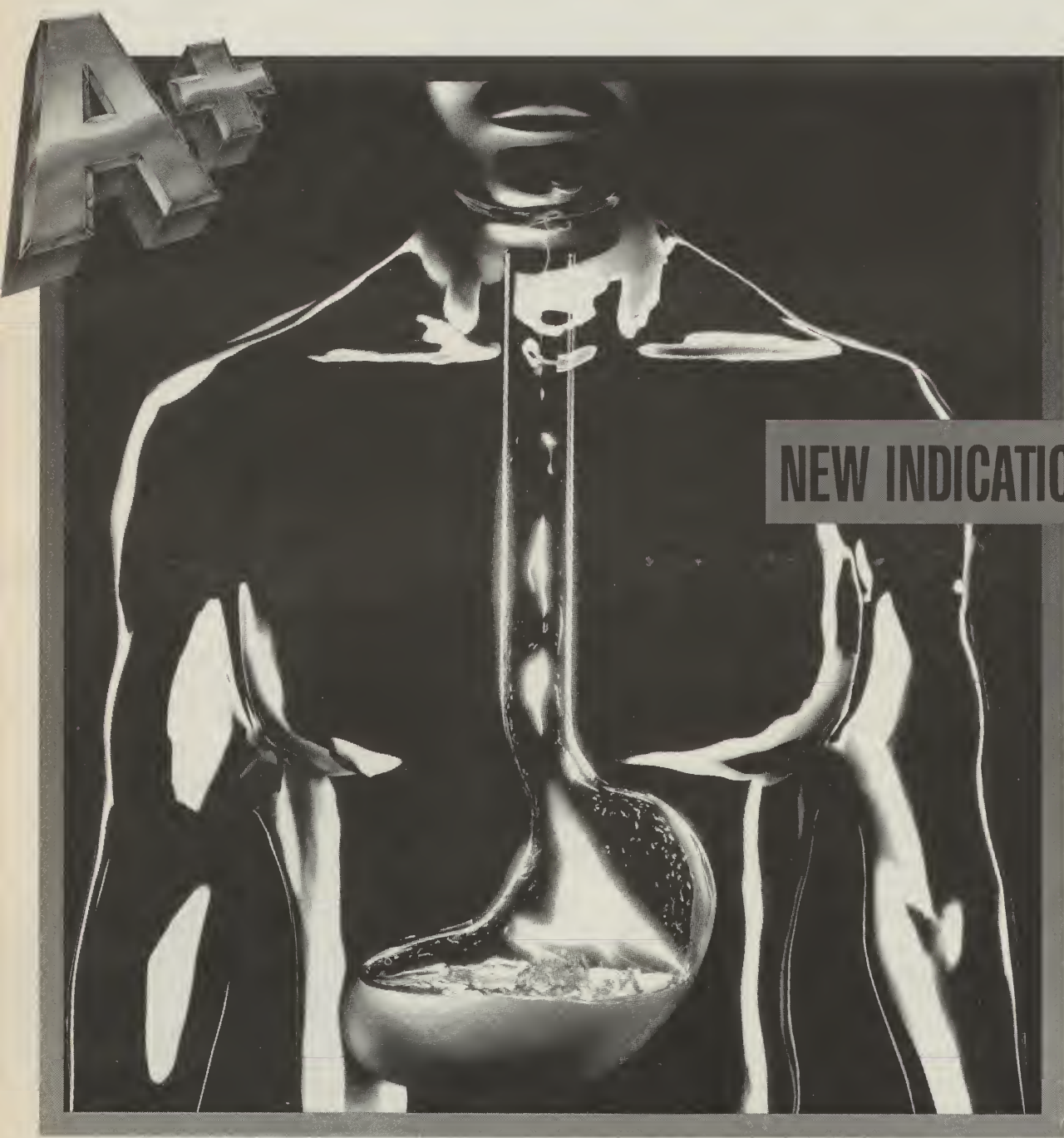
Work, PROs still have as their primary responsibility the medical review of services reimbursed by Medicare. PROs review such services to ensure that they are: (a) medically necessary, (b) provided in an appropriate setting and (c) meet professionally recognized standards of care. All PROs are beginning to implement the Fourth Scope of Work this year.

## Quality Intervention Plan

Cases selected for review by PROs under the Third Scope of Work are passed through six generic quality screens, identical to those used in the Second Scope of Work. However,

the Third Scope of Work also requires the implementation of a Quality Intervention Plan (QIP). The QIP is a plan by which each PRO is required to perform a quality review and implement interventions when quality concerns are identified. The following is an overview of the QIP:

- Every case selected for retrospective review is screened for potential quality problems.
- If a potential quality problem is identified, the QIP requires the PRO to allow 30 days for the physician and/or the provider to comment on the quality problem.



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**Indications and Usage:** 1. Active duodenal ulcer—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

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3. Gastroesophageal reflux disease (GERD)—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests:** False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions:** No interactions have been observed with theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C:** Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Use in Elderly Patients:** Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information). A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase):** possibility of probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular:** In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS:** Rare cases of reversible mental confusion have been reported.

**Endocrine:** Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic:** Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumentary:** Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity:** As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other:** Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdose:** Overdoses of Axid have been reported rarely. If overdose occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

Additional information available to the profession on request.

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- A PRO physician reviews comments submitted within the specified time to confirm or resolve the potential quality problem.
- When the PRO determines a problem exists, the PRO must determine its source and notify the affected party. The notice to the responsible party must include sufficient detail so that he/she will clearly understand the identified problem, what appropriate action should have been taken in the case, the severity of the problem and the action to be taken to resolve the quality problem, if appropriate.
- A PRO physician must assign a severity level to each case with a confirmed quality problem. The three-level severity system is based on the degree of harm or potential for harm to the patient. The three-level severity system was developed with the assistance of physicians representing the major medical specialty societies. The three levels are:

Confirmed quality problem *with* significant adverse effects on the patient (Level III);

Confirmed quality problem *with the potential for* significant adverse effects on the patient (Level II); and

Confirmed quality problem *without the potential for* significant adverse effects on the patient (Level I).

"Significant adverse effect" is defined as (1) patient management that results in anatomical or physiological impairment, disability, or death, or (2) unnecessarily prolonged treatment, complications or readmission.

• Each case with a confirmed quality problem is assigned a weight based on the severity level of the problem. Each severity level has an assigned

and/or provider) will be notified of the potential quality problem and provided with an opportunity to respond and discuss the issue with a PRO physician. The initial notification should include sufficient detail so that the responsible party will clearly understand the identified problem and the severity of the problem.

#### How to respond

Following is a list of steps to take on receipt of a letter of inquiry regarding quality concerns from your PRO:\*

**Step 1.** Keep calm. Do not send angry letters back to the PRO; discuss the quality issue with a peer.

**Step 2.** Review the medical record to make sure the PRO has not made a factual error in its review of the case. The PRO may have overlooked a

critical entry in the medical record.

**Step 3.** Physicians receiving letters of inquiry from their PRO should carefully consider whether or not to telephone their PRO about the case. A preferred course is to write to the PRO, with a copy to the chief of the hospital medical staff, instructing the PRO to communicate its concern to the chief of staff and departmental chairman.

In your communication with your PRO, you should present factual information without self-serving statements, argumentative remarks, explicit or implicit admissions of error in judgment, or criticism of care provided by others.

**Step 4.** You may opt to request a personal interview with the district medical director and specialist consultant before writing a response. A personal interview may be more appro-

priate than writing, particularly in a complicated case.

**Step 5.** Keep your response in a separate file other than the patient's medical record. Keep all communications separate so that they are not inadvertently disclosed if the medical record is produced in response to a subpoena.

As always, detailed histories and patient records should be retained because they assist in the recollection of relevant facts involved in the treatment. They may also explain to the PRO reviewer why a particular treatment was chosen. ▲

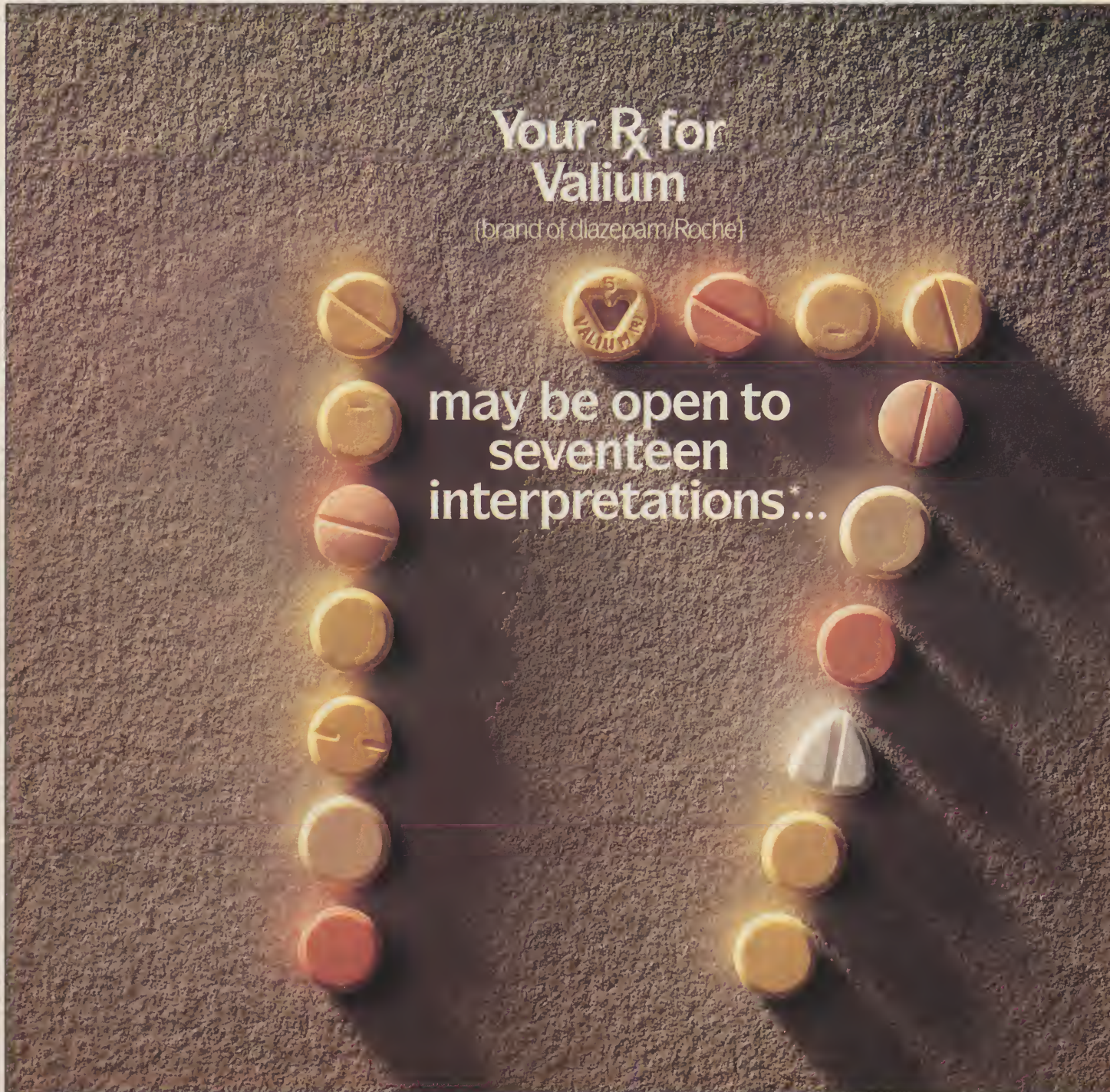
\*The AMA notes that steps 3-5 were adopted with permission from the California Medical Association's brochure "What Physicians Should Know about Working with CMRI and Other Review Organizations."

*In your communication with your PRO, you should present factual information without self-serving statements, argumentative remarks, explicit or implicit admissions of error in judgment, or criticism of care provided by others.*

weight, from a weight of 25 for a Level III problem, to a weight of 5 for a Level II problem, to a weight of 1 for a Level I problem.

• Each quarter the PRO will profile the total weights accumulated for reviews completed in that time by a problem source (e.g., physician and/or provider). The total weight will determine the corrective action. When the quarterly profile shows that a particular physician has a total weighted score of three points or more, the PRO must initiate corrective action.

The Third Scope of Work states that when a severity Level II or Level III quality problem is identified, or a pattern of severity Level I quality problems are identified, the responsible party (i.e., the physician



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## Illinois UR firm

(continued from page 1)

A cancer patient is hospitalized for several days for pain, but the pain is not yet under control. A utilization reviewer working on behalf of the patient's employer makes certain an extended hospital stay will be covered until necessary hospice services can be arranged.

Six nurse reviewers from Health Care Consultants, a utilization review firm in Rockford, routinely handle cases such as these. Working with the firm's physician medical director and 45 physician reviewers in practice in the Rockford area, they see themselves as partners with physicians and patients alike.

"Our medical director and physicians are willing to discuss problems peer to peer," says Johanna Lund,

HCC president and chief executive officer. "If physicians are aware of what our protocol is, they receive us very well. If they've had a bad experience, they are unsure of our purpose and there may be a conflict.

"We understand the process is intrusive," she continues, explaining that HCC makes nurse reviewers available to speak with patients and physicians 24 hours a day. "We try to make it very easy to contact our physician [reviewers]."



Jon McGinny

*"Time is the main factor. Do I call the physician or do I call our medical director? How critical is this?"*

— Reviewer Mary Panther, R.N.

Terry Groncki, HCC director of review services, explains that patient pre-admission information is usually verified and relayed to attending physicians through their office staff to avoid causing any undue hassle. "Our nurses are up to date on protocol, and if a physician is not readily available, we try to be as cooperative as possible," she says.

At Health Care Consultants, a small review company, it is the patient's responsibility to make initial contact with the firm when surgery is scheduled, further removing the burden from the physician. Two forms of review take place at HCC: telephonic, in which hospital pre-admission certification information is collected from either the patient or the physician's office; and concurrent, which may be on-site at any of 17 hospitals in and around Rockford.

While the majority of HCC's clients are private self-insured companies, not insurance companies, several have chosen a third party administrator for claims, and utilize HCC's services for UR.

### Working with people

Kathy Palches, R.N., who does telephonic review for HCC, says she was afraid that working only over the phone would keep her from one of the things she loves most about nursing: working with people. But she has found that she enjoys working with patients over the phone.

"I enjoy the aspects of talking with people, and I think of myself as part of the treatment team," she says. "As a nurse, the patient is my first concern."

As a reviewer, Palches is polite and works fast, noting all pre-admission

certification information as quickly as possible. In many cases, she is familiar with patients from past experience, and is able to keep their specific needs in mind when referring to criteria for length of stay. "When working with patients or physicians, we have to be as patient and calm and generous as possible," she says.

When collecting pre-admission certification information from patients, she says she often has to leave a lot of blanks. It is common for husbands whose wives are on their plan to call in when their wives are pregnant, she says. They often won't have the name of their wives' doctors, and other information. "They're always stumped on their wives' date of birth," she says.

Palches says it is left up to the employer-clients to develop a policy on what services should be pre-certified. Length of stay is determined by national criteria, which may be less than what physicians recommend for patients, she says.

"It takes a lot of explaining for patients to understand why we determine how much time in the hospital will be covered," Palches says, noting that a shorter length of stay than the physician requests is usually approved to save money if all goes well, and can be extended as complications arise.

Nurses don't make the decision to deny coverage, she says. "In the end, it is a [reviewing] physician's decision, not ours."

### On the beat

On her morning visits to Rockford's SwedishAmerican Hospital and St. Anthony's Hospital, Mary Panther, R.N., takes time to solve problems as she drives between the two.

"When I'm starting a chart it's hard for me to make decisions with all the commotion at the hospital," Panther says. "For me, it's 'Get down what you need and make the decision someplace else.'"

Panther spends much of her hospital time checking to see that scheduled discharges have actually taken place. If patients have not left, she



Jon McGinny

*"We do not request information from a physician without a release from the patient. If a release is not signed, we don't review the chart."*

— Terri Groncki, HCC director of review services



Jon McGinny

*"I enjoy the aspects of talking with people, and I think of myself as part of the treatment team. As a nurse, the patient is my first concern."*

— Reviewer Kathy Palches, R.N.

needs to find out why. She checks the patient's charts, and if the reason isn't evident she must consult the physician.

"Time is the main factor," she says. "Do I call the [patient's] physician to call our office back, or do I call our medical director right now? How critical is this?" she often has to ask herself.

While Panther is interested in saving money for clients, she realizes that complications do occur, and works closely with hospital physicians when extensions are necessary. If a patient is scheduled to depart, she will often leave a reminder note on the chart for the physician.

### Confidentiality stressed

Although experts say that obtaining a patient's release before contacting a physician for information is atypical of most utilization review firms, HCC officials say they are adamant about patient confidentiality.


"We do not request information from a physician without a release from the patient," Groncki says. "If a release is not signed, we don't review the chart, we don't make a decision and it becomes private pay," which means the patient becomes responsible for the bill.

But even if reviewers obtain a release, confidential patient information is not given to the insured's employer. HCC reviewers sign confidentiality contracts when they are hired, and follow specific protocol, Groncki says.

In addition, HCC reviewers constantly work to improve communication skills.

"Our nursing staff is very comfortable explaining our purpose," Lund says. "The physicians we work with are familiar with us and what we do. They are familiar with UR in general."

"I routinely explain that we are patient advocates," says Groncki. "The more information a doctor shares with us, the easier it is to work as a team to provide services for that patient." ▲

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## Utilization review

(continued from page 1)

authority figure to their patients and patient loyalty reflects this.

"So when a reviewer challenges all of that by questioning the care a physician prescribes, there could be a sense of intimidation or irritation on the part of physicians," Dr. Schmidt explained. "Receiving a telephone call from a reviewer and not knowing who that reviewer is or what their qualifications are is probably the most irritating. It would be easier to accept a critical challenge from a peer with a like background to your own than from someone you don't know."

Most physician complaints center on independent review companies that hire out to businesses or insurance companies to perform review activities. The trend today is toward employers and insurers using these external review firms instead of a hospital's utilization review department. Some companies and insurers believe internal review is akin to "allowing the fox to watch the henhouse," said John F. Schneider, M.D., ISMS Third District trustee and immediate past chairman of the ISMS Council on Economics. "Pragmatically, though, it should be the responsibility of the institution to perform utilization review - high-quality care should be incentive enough on its own," he said.

### Reviews may waste money

Because external review firms are typically paid according to the number of reviews they perform, their incentive is to monitor as many cases as possible. In reality, however, Dr. Schneider said the vast majority of care delivered is appropriate, so the reviews themselves may be wasting money instead of saving it.

Reviewers could make better use of their resources by focusing on those few physicians or institutions that may be delivering "less efficient care," Dr. Schneider said. "But presently that's not being done. They review everybody.

"The motivating force behind uti-

lization review is an assumption that services are being provided unnecessarily or are being provided in an inappropriate setting, such as in an acute care hospital when a nursing home would be sufficient," Dr. Schneider said. "The goal for physicians is to provide necessary services in the most appropriate facility, making the most effective use of resources."

That goal is difficult to achieve, he said. As part of a pre-admission certification, a reviewer determines whether the patient actually needs the treatment or service the doctor recommends. The reviewer ensures that "explicit criteria" are satisfied, thus demonstrating the service is necessary, Dr. Schneider said. But because medicine "isn't that easy or straightforward," the better review firms fold in another layer of review,

or "implicit judgment," that includes a referral to a physician reviewer so "an exchange between the two physicians can take place," he noted.

When a patient is hospitalized, internal and external reviewers use additional criteria based on illness severity and intensity of the services provided to justify the patient's continued stay. The reviewing entity examines whether the patient is in the hospital for "non-acute care days," he said. Reviewers look at the patient's stay day-by-day, asking why a patient is still in a hospital if the criteria indicate discharge is appropriate.

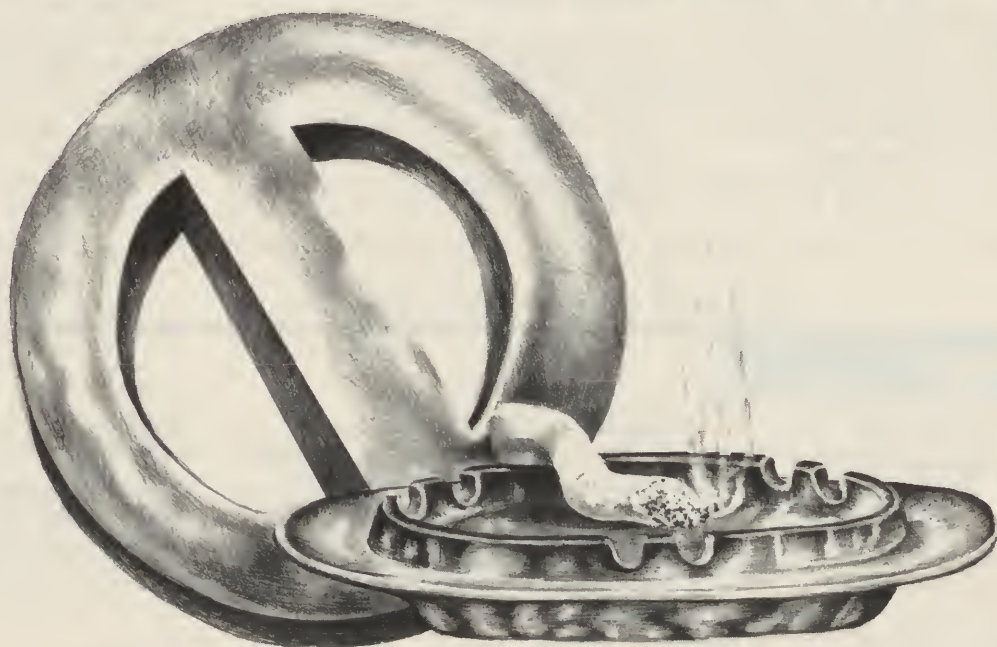
For example, a patient scheduled for surgery may develop a fever, necessitating postponement of the procedure. Or a test may be ordered that is not readily available, Dr. Schneider said. When an extenuat-

ing or special circumstance arises, physicians should note reasons why the service is not being provided efficiently in the patient's record.

In addition, utilization review has increased the burden on physicians to perform adequate discharge planning for their hospitalized patients. A patient who could receive care at home or in a nursing home should be discharged to that next stage as soon as it is appropriate. Dr. Schneider recommends that physicians plan early for services needed after discharge, so gaps in care or insurance coverage do not occur.

"If a patient is going to require the services of a visiting nurse and the physician fails to order the service, the patient could end up back in the hospital," he said. "It could become a quality concern for the doctor." ▲

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## The types of UR

*Utilization review is a broad, catchall phrase used to describe the different types of assessment performed by third party payers of medical care. Three basic categories of utilization review are in widespread use today:*

- **Mandated review of government-paid care.** In Illinois, this frequently takes the form of the reviews performed by the Crescent Counties Foundation for Medical Care for Medicare and the state's Medicaid program.

- **In-house review efforts by a hospital or an insurer.** Examples include the varied utilization review programs undertaken at Blue Cross and Blue Shield of Illinois.

- **Independent review provided by external firms.** The sole business of these companies is performing utilization review. These external review firms market their services to insurance companies or self-insured businesses to do utilization review for their health care plans. Examples include Downers Grove-based Healthcare Compare and Rockford-based Health Care Consultants. ▲



Illinois Medicine asked utilization review professionals:

## What is the most common problem you see that triggers a review?



**Janis Orlowski, M.D.**  
Assistant Medical Director  
Rush-Presbyterian-St. Luke's  
Medical Center, Chicago

"Lack of documentation. The doctor saw the patient, examined the patient, made an excellent diagnosis, but didn't document it. Unfortunately, the latter is the only thing the outside reviewer looks at."



**Fidel Davila, M.D.**  
Medical Director,  
Quality Improvement  
Blue Cross and Blue Shield  
of Illinois, Chicago

"It's the lack of discharge planning. There's nothing going on that's active. The patient has actually finished treatment, the patient is not being actively treated and there are no plans to discharge."



**Marylyn Gagliardo, R.N.**  
Executive Director  
Central Illinois Medical Review  
Organization, Champaign

"Documentation doesn't support the need for hospitalization. Many cases that are initially denied are later reversed on reconsideration after documentation is provided."



**Eileen Green, R.N.**  
Quality Assurance Nurse  
MacNeal Hospital, Berwyn

"The most common problem I see is that patients and families do not understand that hospitals are for acute care only. They want to stay after the acute phase of the illness or hospital service is over. Health care can be delivered in settings other than the hospital through the coordination of home care and community services." ▲

Interviews by Kathy Meyer. Photos by Wm. Daniels/The Photo Partners; M. Candee Studios; Brian K. Johnson; Mark Garrett/PCI.

## Obituaries

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

### \*Daczyszyn

John Daczyszyn, M.D., of Chicago, died October 26, 1991 at the age of 75. Dr. Daczyszyn was a 1947 graduate of Medizinische Fakultät der Johann Wolfgang Goethe Universität, Frankfurt-am-Main, Hessen, Germany.

### \*Mundt

G. Henry Mundt Jr., M.D., of Western Springs, died April 30, 1991 at the age of 76. Dr. Mundt was a 1941 graduate of Yale University School of Medicine, New Haven, Conn.

### \*\*Olivieri

Ernest P. Olivieri, M.D., of Mt. Prospect, died September 25, 1991 at the age of 82. Dr. Olivieri was a 1934 graduate of Loyola University Stritch School of Medicine, Maywood.

### \*Rowlette

Raymond S. Rowlette, M.D., of Northbrook, died September 3, 1991 at the age of 74. Dr. Rowlette was a 1945 graduate of Chicago Medical School.

### \*\*Slatin

Louis Slatin, M.D., of Decatur, died September 3, 1991 at the age of 90. Dr. Slatin was a 1928 graduate of Loyola University Stritch School of Medicine, Maywood.

## Regulation of UR

(continued from page 3)

would at least offer a security check for physicians.

- Regulation could also establish rules of conduct for reviewing organizations, Dr. Schmidt said. This could include, but need not be limited to, criteria for reviewer qualifications or, at minimum, a rule calling for reviewers to have adequate qualifications.

"This would at least set some expected standards," he said. "For example, an R.N. reviewer should have verification of some qualifying training. What form that would take is a sticky wicket. But even physician reviewers need to take some training course. Now there is no standard."

- Another goal of regulation is implementing standard protocols for reviews and reporting. Just as the insurance industry and the government are instituting the 1500 universal claim form for health insurance billing, reviewing entities around the nation also could use a standard form. Illinois physicians receive telephone inquiries from reviewers in other states and no two firms use the same reviewing format, Dr. Schmidt noted. "A standard return mail form would set a quality standard advantage," he added.

In addition, requiring standard protocols for reviews would level the playing field for physicians and reviewers because doctors would know the rules.

Regulating the independent review industry will be a long and drawn-out process, most observers agree. "But at least we're moving in a direction to stimulate positive debate," Dr. Schmidt said. ▲



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## ISMS budget

(continued from page 1)

nual meeting effective 1992, but last year the Board of Trustees was able to recommend that the dues plan be extended to cover the 1992 budget.

"And early indications are," said Dr. Reardon, "that next year we will be able to repeat that recommendation."

"The 1992 budget was built on two key objectives," said ISMS Secretary-

Treasurer Alfred J. Clementi, M.D. "The first is to maintain and, where possible, to enhance the Society's strength for its members. The second objective is to stretch the current three-year dues plan beyond the fourth year [1992] and into a fifth [1993]."

### Surplus in 1991

Projected 1992 revenues of \$6.1 million, a 2.4 percent increase over 1991, are matched against projected

expenses of \$6.4 million, a 7.3 percent increase. The projected \$289,525 deficit for 1992 will be offset by a projected \$300,000 surplus in 1991, said Dr. Clementi. "This surplus will preclude any need to dip into the Permanent Reserve Fund to cover the shortfall."

Dr. Clementi cited two factors contributing to the positive results. First, only two new programs have been added to the 1992 budget and 1991 expenses were diligently controlled, resulting in the budget surplus.

Major changes on the expense side of the 1992 budget include Governmental Affairs, where expenses are up 30.9 percent, attributed to costs associated with the Society's Washington presence initiative and elec-

tion year activities. ISMS members consistently cite the Society's governmental operations as one of its most effective and important member services.

A 14.1 percent increase in 1992 expenses for Membership and Marketing is attributed to additional costs in the Physician Assistance Program, expenses that are funded by a grant from the Illinois State Medical Insurance Exchange. Society 1992 revenue from grants also rises 18.8 percent in 1992. A transfer of funds from the Educational and Scientific Foundation to help fund the cost of the Clinical Lab Improvement Act (CLIA) awareness campaign accounts for a 59.1 percent increase in other 1992 Society revenues. ▲

## Vaccination

(continued from page 1)

education is key to this law.

"[Parents] need to know that although they are rare, injuries can occur," he said. "[The information] needs to be presented in a way that proves the benefits far outweigh the risks."

The written information must include details of each disease the vaccine is designed to prevent; symptoms or possible reactions to the vaccine; symptoms of adverse reactions; measures to take to reduce the risk of adverse reactions; contraindications to, and bases for the delay of, administration of the vaccine; a description of the manner in which major reactions should be monitored, including a form for recording symptoms; notice of the availability of the National Vaccine Injury Compensation Program; and a summary of the federal recommendations concerning the complete schedule of childhood immuniza-

tions.

By arrangement with the CDC, IDPH will supply physicians with camera-ready copies of each brochure by April 15. Physicians may reproduce the material, according to the CDC, provided all specifications of the law are met.

Penalties for not complying with the law are not listed; nevertheless, Dr. Berkelhamer believes the new law will encourage communication between physicians and patients. He cautions, however, that physicians may spend too much time discussing a child's vaccinations when other important health issues need attention.

"I don't know that this brochure will make my practice easier, or just create headaches," he said. "We'll have to wait and see."

Physicians who have not received their camera-ready copies by April 15, or would like additional information about the new vaccine rules can contact IDPH's Immunization Program at (217) 785-1455. ▲



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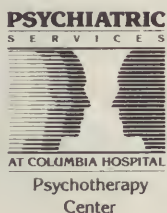
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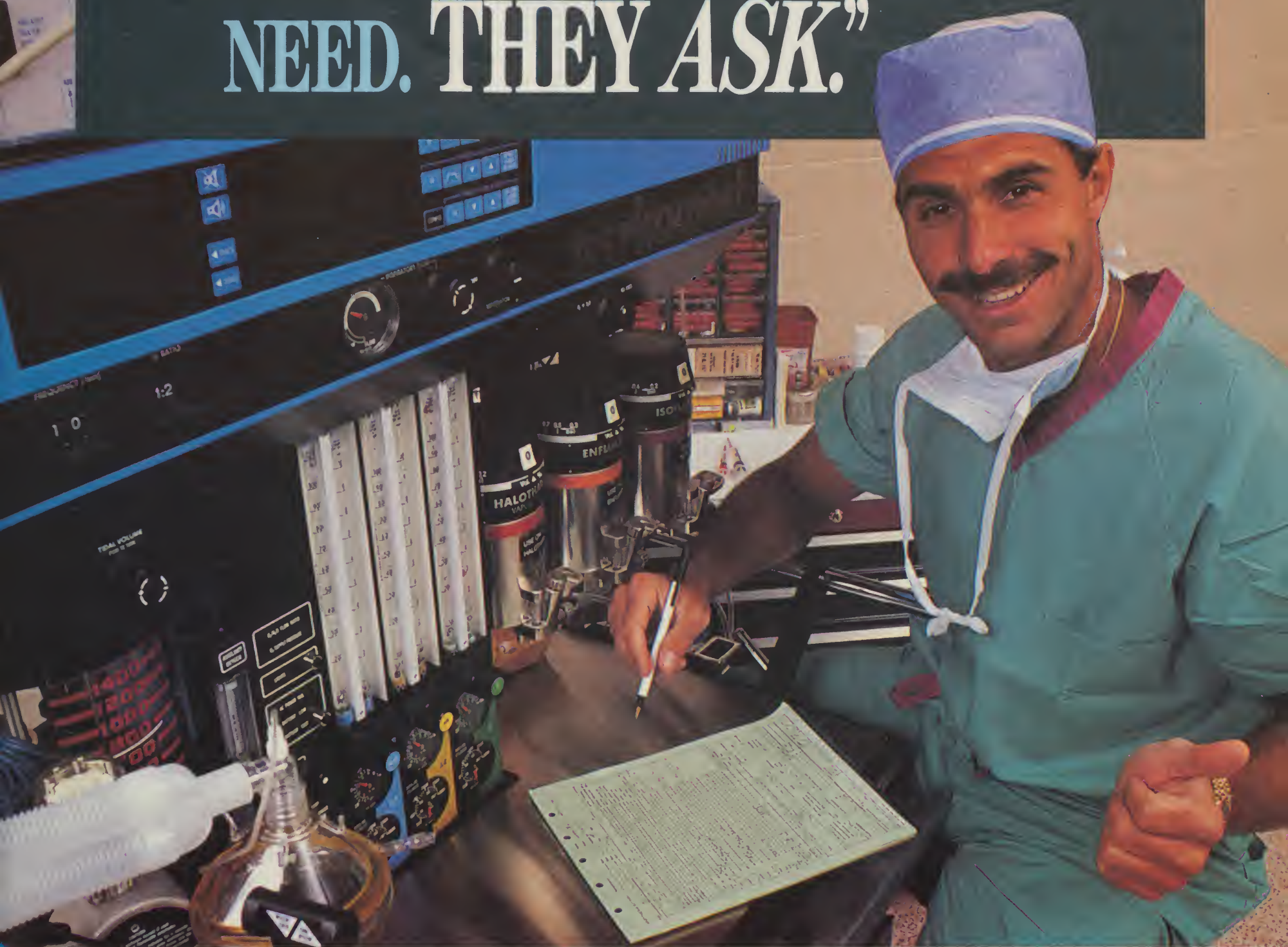
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A black and white portrait of Harold L. Jensen, M.D., an older man with glasses, wearing a suit and tie, looking slightly to the side.

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# Illinois Medicine

Concerns mount over "runaway" jury verdicts ..... 6

February 28, 1992

ILLINOIS STATE MEDICAL SOCIETY



An ISMS delegation visited Ontario on a fact-finding trip to learn about Canadian health care. ISMS President Robert M. Reardon, M.D., (left) listens to a nurse's perspective at Toronto's St. Michael's Hospital.

## ISMS leadership gets firsthand look at Canadian health system

EVERYONE, THESE days, has an opinion about the Canadian health care system. Some look to our northern neighbor as a model for health care reform here. Others decry Canada's system, citing decades-old technology and long queues of patients awaiting critical care.

Who is right? Illinois State Medical Society leadership set out to find some answers, traveling to Ontario Jan. 30-31 to meet with health officials and physicians there.

"It was an interesting trip that gave us an entirely new perspective," said ISMS President Robert M. Reardon, M.D. "There are lots and lots of anecdotal misperceptions floating around America about what Canada's

health system is all about."

Perhaps most erroneous is the perception that the Canadian health care system is national. Instead, it is administered by each of the 10 provinces and two territories. Only a few years ago the federal government contributed 50 percent of the funding to provinces and territories that met five ba-

(continued on page 13)

## Bush renews call for caps

by Kathy Meyer

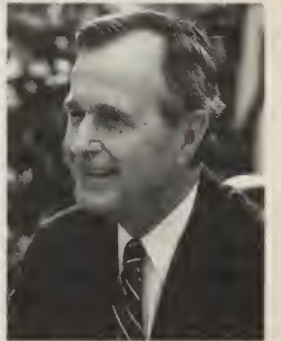
PRESIDENT BUSH renewed his call for caps on non-economic damages in medical malpractice cases Feb. 6, when he unveiled his plan for comprehensive reform of the nation's health care system.

In a speech to Cleveland business leaders, Bush said his four-point health plan is designed to increase access to care, contain health care costs, cut waste and curb the growth in government health programs. He said the plan builds on the existing health care system, making it more efficient, unlike the numerous proposals that call for a complete or partial overhaul.

Malpractice reform is a key element in his plan to curb rising costs, the president said. The plan seeks to reduce the costs associated with defensive medicine

### Key points in Bush's plan:

- Improve health care accessibility through transferrable tax credits and tax deductions for moderate low-income individuals and families, and a deduction for the self-employed.
- Develop basic insurance package to be purchased with tax credit, require insurance to be offered to all groups and eliminate state-mandated health benefits.
- Contain health care costs through malpractice reforms, including caps on non-economic damages; antitrust reforms to broaden safe harbors; reduced administrative costs; expanded use of managed care programs; increased flexibility to states to design their own health care systems; and renewed disease prevention efforts.



through a number of changes to minimize the threat of malpractice litigation.

Heading the list of proposed changes is a cap on non-economic portions of malpractice awards, those awarded to plaintiffs for pain and suffering. The Illinois State Medical Society has long supported such caps to curtail rising health care costs.

"If non-economic awards are left unchecked, they will continue to contribute to

the volatility of medical malpractice insurance, driving up health care costs even further," said ISMS President Robert M. Reardon, M.D.

The average indemnity payout made by the Illinois State Medical Inter-Insurance Exchange, the state's oldest physician-owned malpractice insurer, grew from \$62,420 in 1980 to more than \$260,000 in 1990. In 1991, it jumped to more than \$330,000. The Ex-

(continued on page 11)

## Richard Benbennick named Employee of the Month

RICHARD Benbennick, an Illinois State Medical Society employee known mostly to his fellow workers, was named the Society's second Employee of the Month Feb. 3.

"One of the very important objectives of the Employee of the Month award is to recognize employees whose service is mostly to their fellow employees," said ISMS Assistant Executive Vice President Jeffrey M. Holden. Benbennick received a recognition plaque and a check for \$200 during a brief ceremony at ISMS headquarters in Chicago. His name is displayed in the ISMS reception area on a special plaque listing all winners for the year.



February Employee of the Month Richard Benbennick.

ed his efficiency, attention to detail and, most important, the obvious pride he takes in the work he does, said Holden.

Holden said that Benbennick's willingness to proof ISMS materials sent to him for print preparation is legendary, and that he often catches errors in proofs that have been read numerous times and declared error-free. Holden added that Benbennick has also been

(continued on page 13)

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## ISMS delegates, take note:

The 1992 Illinois State Medical Society Annual Meeting April 10-12 has been moved to Oak Brook Hills Hotel in Oak Brook.



"Sorry ... you want the ISMS ... Annual Meeting ... It's at the Oak Brook Hills Hotel."



## Cook County residents move closer to strike

With negotiations progressing too slowly for their liking, the House Staff Association at Cook County Hospital Feb. 13 requested a federal mediator be brought in to facilitate either a settlement or a strike. The residents, who have been working without a contract for 15 months, said the hospital administration and the county seem unwilling to make any concession on the major issues. The House Staff Association, which represents 450 of the hospital's 500 residents, authorized a strike Jan. 29 by a vote of 232-30.

"We hope we will come up with a solution," Wayne Heimbach, union organizer for the Cook County residents, told *Illinois Medicine*. "We might be surprised with the progress we can make with a mediator. But we need a mediator to proceed to a strike."

Donald Godbold, M.D., a co-chairman of the negotiating team, added that patient care issues top the union's list of concerns. "We're looking for firm commitments on correcting some of the worst problems, and all we're getting are statements of philosophical agreement," he said. "Our patients deserve more."

The residents are unhappy with what they term "poorly planned" layoffs of 150 health care workers at the hospital in December, which they said "seriously disrupted" care in some areas. Other cost-cutting measures also do not sit well with the resident physicians. For example, the hospital is planning to discharge newborns 24 hours after birth instead of the customary 48 hours and eliminate the obstetrical triage area. In addition, the residents are calling

for an attending physician to staff the pediatric emergency room along with the house staff at night and on weekends.

The residents also are fighting for the right to keep their union. While the county negotiates with Chicago-area medical schools to administer the hospital's residency programs, it is refusing to insist that the union and its contract with the county be a necessary component of any takeover agreement.

## Copley sets new site for replacement hospital

After battling more than a year to build a replacement hospital across planning lines in DuPage County, Aurora's Copley Memorial Hospital announced it will forgo its original plans and build a new facility in Kane County. Hospital officials said they plan to build on a 95-acre tract of land the hospital is now purchasing only three miles from the controversial Fox Valley Villages site Copley had originally targeted.

"From the outset, location has been the key issue," said Copley President and Chief Executive Officer D. Chet McKee. "Aurora falls within two state health planning areas, one of which includes Kane County and our existing hospital, the other of which includes DuPage County and our Fox Valley site. Because we are now planning to build the replacement campus in our current planning area in Kane County, our proposed location is now in line with state health planning guidelines." ▲

— by Tamara Strom

## Resident physicians rally at Cook County Hospital

Cook County Hospital resident physician Laura Heitman, M.D., and fellow physicians protest Jan. 29 to call attention to their concerns about the future of their union, and to maintain their role in correcting patient care issues at the hospital. The residents also voted 232-30 in favor of striking if negotiations are not successful. See related news brief, left. ▲



## Quad Cities hospital merger concerns local physicians

by Tamara Strom

LACK OF INPUT in the planning of a proposed merger between two of the Quad Cities' largest hospitals is drawing criticism from physicians who practice at the two facilities. The medical staff members at Franciscan Medical Center in Rock Island and United Medical Center in Moline found out about the merger plans on television and in the newspaper, not from hospital administrators.

"There are positive aspects to the merger," said Richard P. Snodgrass, M.D., Illinois State Medical Society Fourth District Trustee, who practices at both hospitals. "However, the

manner in which the merger was accomplished is perceived by the medical community as inappropriate. The business community with the lay boards and administrations of the two hospitals met in secret for about a year and organized the concept of unifying without seeking the input or advice of active medical staff members."

Cost cutting and avoiding duplication of services were the impetus behind the merger, said Dr. Snodgrass.

In addition, because both hospitals were planning major capital improvement projects, officials say the merger will save about \$40 million in building expenditures over the next

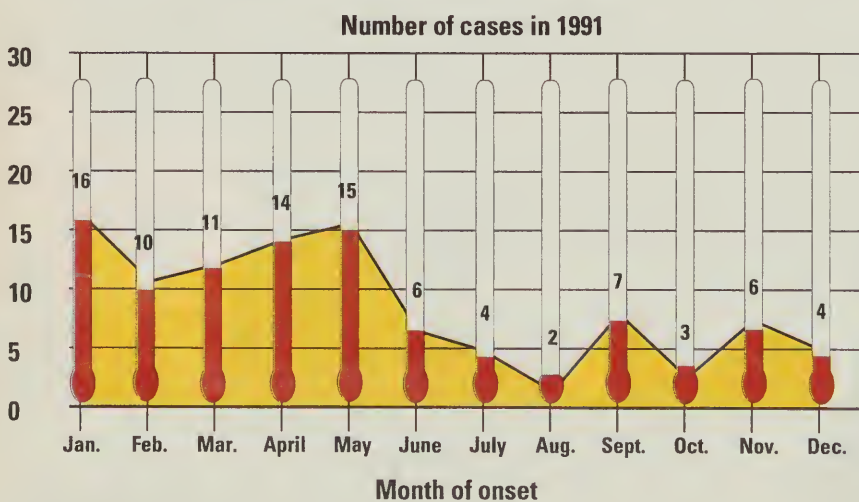
(continued on page 10)

## Corrections and clarifications

Some of the compliance deadlines for the U.S. Occupational Safety and Health Administration regulations on bloodborne pathogens were incorrectly stated in the Jan. 31 story announcing implementation of the federal rules. The rules are effective March 6, and the deadline for completing an office exposure control plan is May 5. The remaining deadlines are: June 4 for physician-employers to begin training and providing information about potential occupational exposures, and July 6 for physicians to provide protective clothing and equipment and to begin vaccinating employees against hepatitis B. *Illinois Medicine* regrets the error. ▲

## Physician Facts

### Invasive *Haemophilus influenzae* in Illinois



Source: Illinois Department of Public Health, Jan. 20, 1992

## IDPR reminds physicians to update addresses with state

by Rachel Brown

WARNINGS, FINES and probation are a few of the penalties levied against physicians who fail to renew their medical licenses on time. To help physicians avoid these unnecessary penalties, the Illinois Department of Professional Regulation mails renewal applications to a physician's last known address several weeks before the deadline. It is important, therefore, that physicians remember to promptly notify IDPR of any address changes.

Renewal applications are sent about 60 days before the physician's renewal deadline, according to Karen Dunlap, IDPR's assistant program executive of the license and testing division. The current medical licenses will expire on July 31, 1993.

IDPR records show that 161 physi-

cians filed late license renewals during 1990. Of those late renewals, about 15 physicians have already received warning letters, probation or fines; formal investigations have been opened on about 20 more physicians, and additional disciplinary action may be forthcoming.

"The great majority of these [late license renewals] are not intentional," said Joseph B. Perez, M.D., chairman of the Illinois Medical Disciplinary Board. "Just remember that if you move, it's your responsibility to notify IDPR."

The MDB has advised IDPR that physicians disciplined for late license renewal should not be reported to the National Practitioner Data Bank. The board made this determination after reviewing Data Bank guidelines that state that reportable actions

(continued on page 10)

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# State AIDS program targets women

by Anna Brown

THE ILLINOIS Department of Public Health Jan. 30 announced a new HIV/AIDS education initiative targeted to women in underserved areas. The announcement, made at the Cook County Hospital School of Nursing, follows the release of the department's HIV counseling and testing guidelines for women and newborns.

"Last November the department announced recommendations for the counseling and testing of women and newborns for HIV," said John R. Lumpkin, M.D., IDPH director. "The new campaign will build on those efforts."

Three HIV-positive women attended the announcement as spokesmen for IDPH. They, and other HIV-infected representatives, will bring their stories to salons, churches, women's organizations, substance abuse centers and other atypical arenas for AIDS education, Dr. Lumpkin said.

"We have recently seen significant increases in the numbers of women and children affected by this deadly disease," he said. "It is imperative that we make special efforts to reach women with crucial lifesaving messages about the risks of HIV infection and how to protect themselves."

Twenty-five presentations have already been scheduled, Dr. Lumpkin said. The state is financing the program at a cost of \$30,000.

IDPH will distribute posters and brochures warning women of the threat of infection and describing methods of protection. Television public service announcements will illustrate metaphorically how HIV can be spread between sexual partners.

## Reaching underserved and high-risk women

A major focus of the program is the medically underserved areas that traditionally receive little AIDS education, Dr. Lumpkin said. The program will also focus on African-American and Hispanic women, who have seen a 123 percent and 45 percent increase in AIDS cases, respectively, in 1991. Dr. Lumpkin noted the need to deliver the message to these women in a "culturally effective way."

Dr. Lumpkin urged all women who believe they may be at risk to seek counseling and testing from their health care providers.

Mardge Cohen, M.D., director of the Cook County Hospital Women and Children With AIDS program, introduced Novella, Brenda and GiGi, the three HIV-infected speakers, saying, "AIDS knows no sex or race. Education has to be coupled with appropriate services to prevent the transmission of the virus."

Novella, who is African-American, said she will devote her life to the education of women and people of color to promote healthy behavior and encourage early intervention. GiGi, who is also African-American, said she was thankful to be able to endure her illness, and voiced her belief in the need for more outreach programs of this kind. Brenda, who is Hispanic, hoped that Latino people would take advantage of the program, then repeated her message in

Spanish.

"What we are seeing in this program are individuals who have the courage to come forward and to talk, and to have the commitment to help someone else by telling their stories," said Dr. Lumpkin.

## Women have different problems

One of the problems women face regarding HIV and AIDS is insufficient awareness among women and among providers who care for them, said Dr. Cohen. "That is, of course, changing through efforts like this," she said.

Some of the major medical manifestations that affect women are vaginal candidal infections, abnormal



From left: Brenda, Novella and GiGi will help IDPH spread the message about AIDS by speaking to women in places where they gather. All three women have tested HIV positive, and are dedicated to helping others protect themselves.

Pap smears and cervical abnormalities, said Dr. Cohen. "Other early symptoms are really quite similar for both men and women," she said.

"The most important message here is that women who are experiencing

gynecological infections or abnormal Pap smears should, along with their providers, be thinking about issues related to HIV," Dr. Cohen continued. She stressed appropriate

(continued on page 13)

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## REPORT FOR Illinois Physicians

### HOW TO ORDER THE REVISED HCFA-1500 FORM

Instructions for ordering the revised, scannable HCFA-1500 claim form are listed below. A phase-in period from October 1, 1991 to May 1, 1992 has been set by the Health Care Financing Administration (HCFA). During this time, the carrier will accept both versions of the HCFA-1500 form. On May 1, 1992, the carrier will begin accepting only the revised (12/90) HCFA-1500 claim form.

The revised (12/90) HCFA-1500 claim form may be ordered from the Superintendent of Documents, and negatives for the HCFA-1500 claim form may be ordered from the Government Printing Office. The Superintendent of Documents will sell copies of the HCFA-1500. For orders of fewer than 100,000 copies, the form prices are as follows: (All of the forms below are sensor coded)

	Quantity Per Package	Price Per Package	Stock Number
Single Sheet	100	\$ 9.00	017-060-00468-1
2-Part Snap-Out	100	\$13.00	017-060-00469-0
1-Part Continuous	2500	\$50.00	017-060-00470-3
2-Part Continuous	1400	\$54.00	017-060-00471-1

On any order for 100 packages or more to be shipped to one address, you may apply a 25% discount to the prices shown above. For orders of 100,000 copies or more, the Superintendent of Documents can furnish HCFA-1500 forms pre-printed with the Practitioner's name, address, and ID number, or customize the form in certain other ways.

To order, payment should be made by check or money order and sent to:

U.S. Government Printing Office  
Superintendent of Documents  
Washington, D.C. 20402

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Call (202) 783-3238 (SupDocs Order Desk)  
Between 8:00 a.m. and 4:30 p.m. Eastern Time

NOTE: Orders must be placed using the SupDocs Stock Number

The Government Printing Office (GPO) will sell negatives which may be used for printing the HCFA-1500 form. Negatives for the HCFA-1500 form and a specification package may be purchased at a cost of \$20.00. Should you desire to purchase these negatives, please make your check or money order payable to "The Public Printer," and forward with your order to the Asst. Supt. of Dept. Acct. Rep. Div., U.S. Govt. Printing Office, Room C-830, Washington, DC 20401.

Please do not submit a purchase order, voucher, or similar form for purchase, as this office can only process payment by check or money order. Your order will be shipped approximately five work days after receipt.

Note: The draft instructions for completing the new HCFA-1500 have been revised. HCFA's Central Office is now reviewing the instructions. We will keep you posted regarding these instructions.

(2/28/92)



## Editorial

# Health care reform must include caps

**P**resident Bush has unveiled his health care reform plan, and most heartening was his support for tort reform. He proposes to provide incentives to states to enact the various tort reform elements that organized medicine has supported for years.

For the most part, tort reform in Illinois is a reality. The Illinois State Medical Society-supported Professional Liability Initiatives of 1985 and 1987 reduced the number of frivolous suits and stabilized the malpractice climate. These initiatives provide a checklist for reform. But there remains one notable exception: Illinois still needs caps to control "runaway" judgments. From 1990 to 1991, the Illinois State Medical Inter-Insurance Exchange's average award jumped from \$200,000 to more than \$330,000.

The president believes – as do ISMS and Gov. Jim Edgar – that placing a cap on non-economic damage awards will help control health care costs. High awards are increasing in Illinois, and this can be attributed mostly to escalating amounts awarded for non-economic – and non-quantifiable – factors, such as pain and suffering. The most recent example is the award that earmarked \$12 million of a \$14.5 million verdict to compensate the plaintiff's past and future pain and suffering.

When doctors don't have the spectre of those mega-awards hanging over them, they can stop ordering the extra tests and consultations that drive today's "defensive medicine." (The American Medical Association estimates that \$15 billion of the nation's health care costs goes for defensive medicine.) Moreover, caps might go a long way toward relieving the increasingly acute problem of access to quality health care in rural areas. We know, for example, that the risk of lawsuits and high premiums contribute to obstetricians leaving Illinois – 46 Illinois counties are currently without any practicing obstetricians – for states like Indiana or California, where caps have been in place for a decade or more.

Capping non-economic damages is fair. Plaintiffs would be fully compensated for economic losses, such as past and future medical costs and wages. The cap would only apply to that portion of the award that is impossible to quantify and, therefore, impossible to predict and control.

Caps and caps alone won't solve all this nation's health care problems – doctors recognize that. The president recognizes it, too. But his proposal builds on what's good and strong in the current system and takes aim at the factors that exacerbate the situation. And when it comes to caps, we like what we're hearing.

## Resolutions due March 10

**O**ne of the most important ISMS deadlines is imminent. Members of the 1992 ISMS House of Delegates are reminded that resolutions to be considered at this year's annual meeting are due at the ISMS Chicago offices *by the close of business Tuesday, March 10*. Late resolutions received after that date will require approval of the Committee on Rules and Order of Business or a two-thirds vote of the House of Delegates to be considered at the meeting. ▲

## Illinois Medicine

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## President's Column

# The emperor has no clothes – Canadian style

*"Health care costs must be brought under control through reform of the health care delivery system."*



Robert M. Reardon, M.D.

That statement is frequently made by Americans. But this quote actually came from Canadian Deputy Health Minister Michael B. Decter.

An astounding percentage of Americans would trade our current system for the Canadian system tomorrow, no questions asked.

Speaking as a physician who has recently returned from Canada, let me tell you that there's far more to the Canadian system than you see in the press. Truth be told, the Canadian system is entirely different when viewed from the other side of the border. Here's what I found during a recent fact-finding trip to Toronto.

- *The Canadian system is not really a universal system.* The provinces (states) administer the system and there are wide variances between how the different entities administer the system. It's a federally mandated program, but the provinces pay for it. When the system was begun, the Canadian federal government promised to pick up 50 percent of the cost. Now our Canadian sources say that within 18 months the federal payments will end entirely and the provinces will be responsible for the entire bill.

- *Canada is having increasing trouble paying for health care.* "Ontario's health care system can't survive without reform," Decter said.

Its \$50 billion budget is already \$15 billion in the red – that's a 30 percent deficit. In Ontario, health care eats up a full one-third of the province's annual budget.

- *Physician fees differ from province to province and the country is considering closing its doors to immigrant doctors.* When they say the provinces control health care, they aren't kidding. The provinces carefully control the num-

ber of specialists by restricting available residencies. Ontario has 2.5 times as many family physicians as it needs.

And if you decide to cast your lot with the system, pick your province carefully. Each province determines its own medical fee scale, negotiating with the provincial medical society. In Alberta, for instance, the oil boom of the '80s led the cash-rich province to establish a trust fund for health care payments. Now that the boom has turned to bust, the trust fund churns on and physicians in Calgary receive higher fees.

Rationing varies from province to province, too – hospitals close beds or entire wings as their annual funding runs out.

- *Do we want "de-listing" to become an American term?* To "de-list" in Canada means to remove a procedure or treatment from the list of protocols the Canadian system will cover. As funding shrinks, de-listing grows.

The Canadian system needs reform. The changes identified by some Canadians include outcome research, looking hard at managed care, predicting longer waits for high-tech procedures and de-listing procedures that have been covered since the beginning of the system.

True, the emperor has no clothes – and the Canadian health care system is not the panacea some people prescribe. ▲

Robert M. Reardon, M.D.  
President

*Next issue: What's right about Canadian health care?*



## Point/Counterpoint

The following articles first appeared in the Voice of the People section of the Chicago Tribune. They are reprinted with permission.

### All pay for punitive damages



by Harold L. Jensen, M.D.

A JURY RECENTLY decided that \$127 million should be paid to a 70-year-old individual who lost his sight in one eye. Of the \$127 million, \$124 million was for punishing Upjohn Co., a pharmaceutical manufacturing company. This is the largest sum ever awarded in punitive damages in Illinois.

What people ought to know is that the award does not come from a nameless, faceless corporation. It comes from all of us who use pharmaceutical products manufactured

by Upjohn.

We all pay in increased costs for prescriptions and other medical supplies. We also pay because we won't benefit from new products that Upjohn might have produced if it hadn't been forced to reallocate its research and development funds toward higher product liability costs.

Further, we will be paying for a long time because claims and suits will increase. Settlements for similar cases will increase and juries will think it's standard procedure to give outlandish sums to people for punishment.

It's considered unwise and impolitic to take on the wisdom of juries. But this award is so blatantly outrageous, it defies rational explanation. And that's the problem with awards based on non-economic factors. They can't be quantified and they can't be fair. There are no rules and no boundaries, and that's why the non-economic portions are whopping amounts. It's a dangerous process with no accountability; it makes no sense.

In my job as the chairman of the

board of a physician professional liability company, we pay settlements and awards that include non-economic damages. Economic damages, such as medical care costs and future earnings, make sense and can be quantified. When a patient is truly harmed through malpractice, that patient should be compensated for economic losses.

*Non-economic  
damages, such as pain  
and suffering, drive up  
medical care costs  
needlessly and cannot be  
quantified nor  
accurately projected.*

But non-economic damages, such as pain and suffering, drive up medical care costs needlessly and cannot be quantified nor accurately projected. The Illinois State Medical Inter-Insurance Exchange and the Illinois

State Medical Society think non-economic losses should be capped, and we'll continue to ask the Illinois General Assembly to pass caps.

Meanwhile, Upjohn will appeal and the award will probably be whittled down to a lesser amount. But a lesser amount of \$127 million is still excessive and irresponsible and punishes all of us. ▲

*Dr. Jensen, an internist from Harvey, is chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors.*

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### Trust juries in awarding damages



by Philip H. Corboy

WHEN THE FOUNDERS planned out our civil justice system, they entrusted the responsibility for determining the facts and assessing damages to common people – not judges or lawyers or bureaucrats or politicians. Their belief in the common sense of a neutral group of ordinary people was so strong that they placed the right to trial by jury in the Constitution itself.

It is disturbing to read Harold L. Jensen's recent complaint that a jury verdict assessing punitive damages against a drug company "defies rational explanation." Dr. Jensen, the head of a malpractice insurance company, mentions only the amount of the verdict, \$124 million. But what could be more irrational than to conclude that the jury's decision was "outlandish" and "outrageous" without even looking at the facts?

The evidence before the jury showed that Upjohn knew that its anti-inflammatory drug Depo-Medrol was unsafe when injected very close to the eye. Yet even after

the company received reports of patients who were accidentally blinded by the drug, the company did not warn doctors of the danger. Indeed, Upjohn advertised and promoted this use of the drug by ophthalmologists.

The jurors were sensible enough to impose punishment only where it was deserved. The jury specifically exonerated the plaintiff's doctor of negligence. To put it another way, this "outlandish" and "outrageous" jury had the common sense to listen to the evidence that held the doctor in this case not responsible for any damages to the injured plaintiff. Dr. Jensen, whose malpractice insurance company insured the doctor, neglected to point out that his insurance company will pay nothing on behalf of the doctor.

*By putting a dent in profits  
the jury quite sensibly felt  
that those in a position to  
influence the company,  
and other drug  
manufacturers, would give  
higher priority to safety.*

It is true that the amount of the verdict was high and that appellate courts may reduce it. Bear in mind, however, that Upjohn took in \$2.9 billion in revenues last year. If the defendant had been a small compa-

ny or an individual with a gross income of, say \$45,000 annually, an award of the same proportion would be under \$2,000. By putting a dent in profits the jury quite sensibly felt that those in a position to influence the company, and other drug manufacturers, would give higher priority to safety.

Dr. Jensen is not genuinely concerned about large punitive damage awards. In fact, under Illinois law, doctors enjoy special immunity from punitive damages. Instead, Dr. Jensen calls upon the Illinois legislature to impose a cap on non-economic compensatory damages that, he says, drive up medical care costs.

The facts say something else. Large awards of non-economic damages are relatively rare, and there are far stronger influences on malpractice insurance rates. As a result, empirical studies have found that imposing a ceiling on non-economic damages does not reduce the malpractice premiums doctors pay.

The nation's largest malpractice insurer, St. Paul Fire and Marine, reported to the Florida Insurance Commissioner that a cap on non-economic damages in that state would result in "little or no savings to the tort system" and no reduction in premiums. Several months ago, the Ohio Supreme Court struck down Ohio's cap on non-economic damages precisely because of the lack of any evidence that it reduced insurance costs. The plain fact is that insurers reap the benefit from damage caps; physicians and patients do not. ▲

*Philip H. Corboy, senior partner with Corboy and Demetrio, is a past president of the Illinois Trial Lawyers Association.*



# Physicians, attorneys working to curb 'runaway' jury verdicts

by Anna Brown

WITH SOME RECENT jury verdicts in Illinois malpractice cases leaping to multi-million-dollar levels, physicians and attorneys are again taking a close look at why those amounts are awarded and what can be done. The problem, many believe, lies in overblown non-economic damages assessed by angry or sometimes overly sympathetic juries.

"Runaway awards are a major factor in today's increasing health care costs," says Harold L. Jensen, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors. "The Exchange's philosophy is to settle a case when obvious negligence has occurred. In all other cases, the Exchange's policy is to defend vigorously."

"It is true that if we take a case to trial we do not anticipate runaway awards," says Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors and former chairman of the Physician Review Committee, which determines whether the Ex-

change will defend or settle a case. "But juries are notoriously unpredictable. A method for preventing runaway awards should be implemented. One of the best ways to accomplish this is caps on non-economic losses."

The Exchange has long supported caps on non-economic damages, a tort reform measure that would limit jury awards for pain and suffering.

## Recent awards make news

Several multi-million-dollar jury ver-

dicts have been handed down in Illinois in the past year. In a recent malpractice case, a plaintiff was awarded \$14.5 million, most of which was for non-economic damages, including past and future pain and suffering. The award was in excess of the physician's policy limit.

Robert Clifford, the plaintiff's attorney in the case, says, "I can't point to more than a couple of instances of a physician having to pay more than his or her policy limit. Unless a 'bad faith' claim can be filed against an insurance company, the plaintiff doesn't stand a chance to collect. The physician's actual out-of-pocket expenses are really very low."

Nevertheless, Dr. Boren says that in the current malpractice environment where such awards are possible, physicians should carefully assess their policy limits to assure and maintain adequate coverage.

Clifford says that while he is against inappropriately large awards for non-economic damages, "big verdicts are a fact of life." In other cases

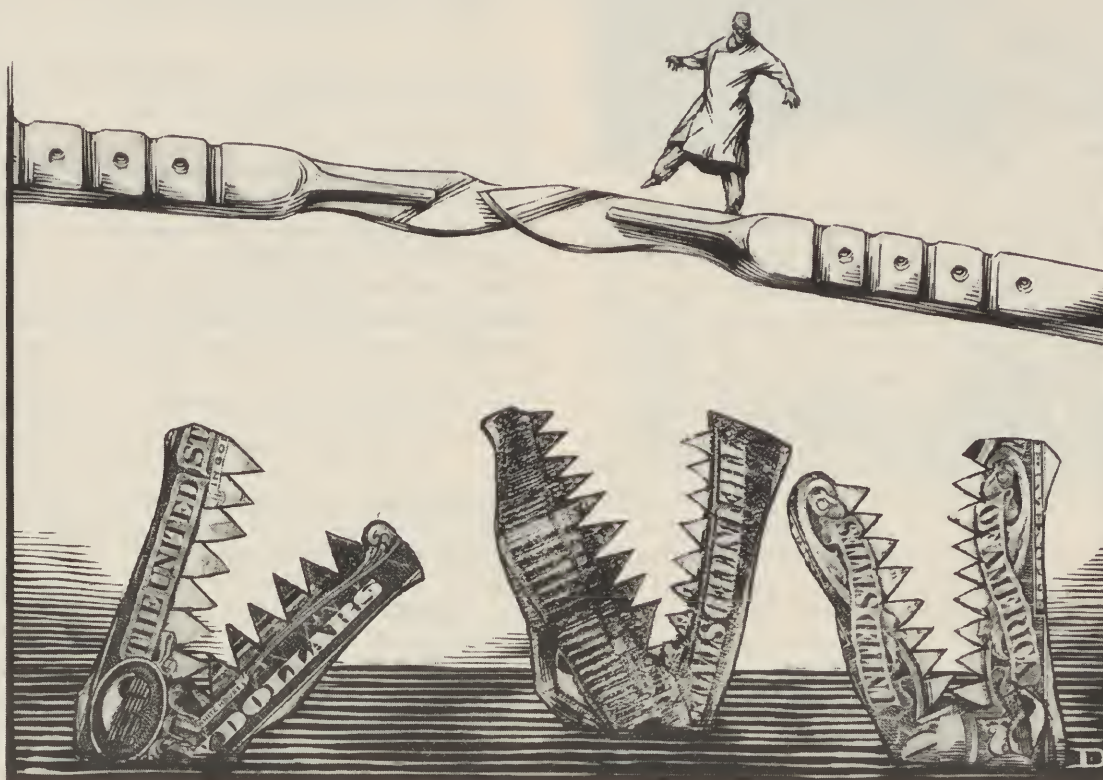


Illustration: Bob Dahm

## Exchange Board Briefs

The Illinois State Medical Inter-Insurance Exchange Board of Governors met Jan. 24 at the Illinois State Medical Society Conference Complex in Chicago. Following are highlights of the meeting.

### Investment guidelines adjusted for quality, flexibility

To provide flexibility to respond to changes in the economic marketplace and to maintain quality, the Exchange amended its investment guidelines to spread out maturities of new purchases and to build up short-term market position. The Exchange also agreed that it could maximize investments safely by increasing its A+ rated investments.

The Exchange investment guidelines, in place since the creation of the company, protect policyholders and reduce the premiums paid by policyholders by the amount earned on investments.

### Attorneys, Exchange representatives meet

Sixty-four attorneys from the major law firms that provide defense services to Exchange policyholders attended an Exchange-hosted meeting in December. During the meeting, Exchange officials explained the Exchange's renewed commitment to quality and aggressive defense for its policyholders. Exchange representatives also promised renewed cooperation between the Exchange and defense attorneys. Defense attorney guidelines developed by the Exchange will be improved with input from defense attorneys. The Ex-

change recognizes that attorneys who defend its policyholders are valuable members of the defense team, and ongoing communication is necessary between the Exchange and defense law firms throughout the state.

### Speakers bureau planned

The Exchange is developing a variety of general and specialty-specific presentations designed to prevent claims and suits and to reduce losses. These presentations will be offered through a newly formed speakers bureau.

The Exchange will offer speaker training for physicians interested in making risk management and other Exchange presentations. The Risk Management Committee is planning speaker training sessions to improve presentation skills of physicians who address county medical societies, hospital medical staffs and clinics.

### Third physician support group program scheduled

Newly sued physicians and their spouses will have a chance April 29 to obtain information and support from Exchange physicians and staff at the Marriott Lincolnshire, when the Exchange hosts its third physician support group session. A physician who has been sued conducts the session, along with a defense attorney and an Exchange Claims Division representative. Policyholders and their spouses who attended previous sessions say they were better equipped to handle the stress of

dealing with their lawsuits after attending the program.

### Exchange to study peer review mechanism

The Exchange Board of Governors will study the peer review mechanisms and procedures used by the Exchange and its attorney-in-fact, the Illinois State Medical Insurance Services, to ensure that these meet policyholder needs. The Exchange will work closely with ISMIS Board Chairman Phillip D. Boren, M.D., in preparing this study, which will focus on the work of the Physician Review and Evaluation Panels (PREP) and the Physician Review Committee (PRC). The PREP committees are composed of physicians who determine the status of continued or new insurability of physicians; the PRC reviews claims and suits to determine whether to defend or settle.

### Exchange responds to Data Bank survey

Responding to a survey of 20 malpractice insurers by the U.S. Department of Health and Human Services Office of the Inspector General, the Exchange reported that one hour of staff time is now required to complete a National Practitioner Data Bank report.

The survey also sought reaction to the prospect of reporting open claims. The Exchange responded that such a move would result in a 500 percent increase in the number of claims to report, at an annual increased cost of \$100,000. Those reports would also be less accurate,

since little is known about open claims before extensive investigation.

The Exchange told the OIG that many open claims are non-meritorious and result in no payment. Further, reporting information on open claims could have serious legal ramifications: Such information would be detrimental to the Exchange's ability to defend its policyholders and involves privileged information between the policyholder and attorney. The Exchange stated further that, "It is astounding that consideration is being given to requiring reports on open claims to the Data Bank," since evidence suggests the Data Bank is unable to satisfactorily process the volume of current reports.

### Exchange to host annual meeting luncheon

The Exchange will host a luncheon April 11 for delegates and alternate delegates to the 1992 Illinois State Medical Society House of Delegates annual meeting in Oak Brook. Valuable information will be provided about the Exchange's new 1992-93 policy year changes.

### Exchange to help physicians planning for retirement

The Exchange will develop and distribute information physicians need to know about preparing for retirement. The Exchange recognized this need to help physicians make informed decisions about the level of professional liability protection necessary in the years immediately preceding retirement. ▲



he feels they are justified. "If you cut off someone's limb, for example, the non-economic damages will be enormous," he says.

He adds that, in his experience, juries have consistently turned substantial verdicts both for and against the plaintiff solely on the basis of evidence. "It's easy to criticize [a jury] when you're not there," he says.

#### **No reasonable relation to injury**

Defense attorney Maurice Garvey of Bollinger, Ruberry & Garvey, defines a runaway verdict as one that is so high it "bears no reasonable relation to the injury." He says this often occurs when a jury sympathizes with the plaintiff or, more often, the jury is angry.

Last year, Garvey successfully defended a physician in a product liability case in which a jury awarded a \$127 million judgment — \$124 million of which was for non-economic loss — against Upjohn Co. The verdict holds the record for the highest punitive damages award in Illinois.

*"Juries are notoriously unpredictable. A method for preventing runaway awards should be implemented. One of the best ways to accomplish this is the addition of caps on non-economic losses."*

"Defendants have to get inside the mind of the jury," he says. "It's very hard to defend when a jury finds the conduct of the defendant egregious."

He says the jury may find something about the defendant that makes it angry, such as his or her

conduct or personality. "It's conceivable that they could get mad at the lawyer," he says, noting that he always asks juries not to blame his client if they don't like him.

"Physicians should be professional without seeming aloof when talking about medical malpractice," Garvey says, emphasizing that defendants should be "articulate, knowledgeable and caring, without appearing arrogant."

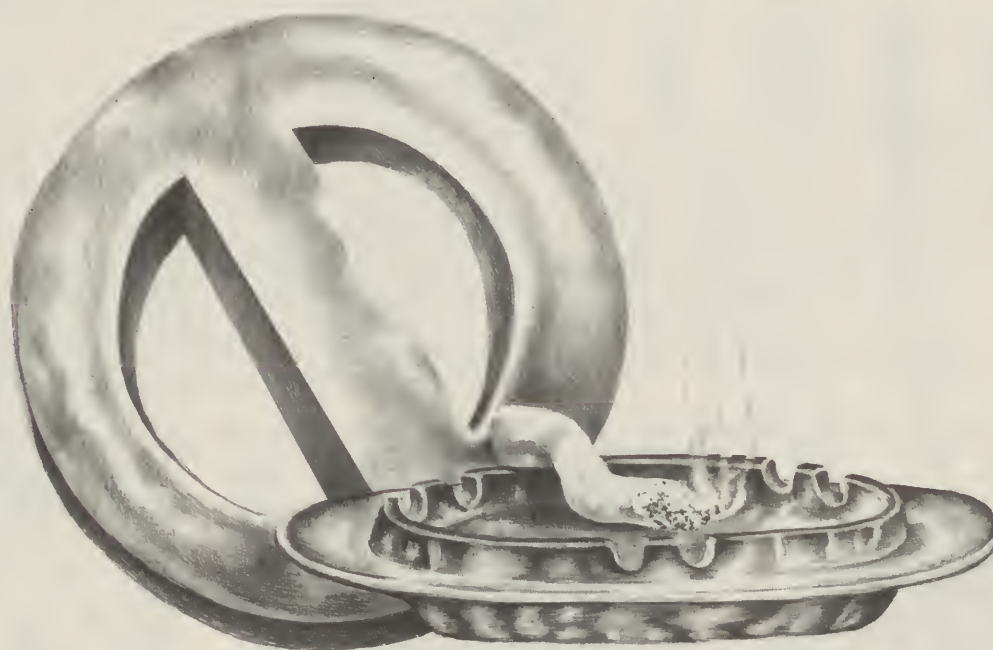
Garvey stresses that medical records should never be altered "after the fact." He says that sometimes physicians innocently believe they are completing the record, but the jury might not find that to be so. "It doesn't have to be intentional," he says. ▲

## **Risk management seminar featured at Midwest Clinical Conference**

THE ILLINOIS STATE Medical Inter-Insurance Exchange will sponsor a risk management seminar focusing on non-medical sources of liability during the Chicago Medical Society's Midwest Clinical Conference. The seminar will be held March 1 from 8 a.m. to noon at the Fairmont Hotel in Chicago, and is open to all physicians.

Three speakers will address communication and documentation issues involved in reducing and preventing risk. Moderator Alfred J. Clementi, M.D., a member of the Board of Directors of the Illinois State Medical Insurance Services, will present "Reducing Your Liability Through Accurate Record Keeping"; attorney Gail Allyn Omahana, of Landau, Omahana & Kopka, Ltd., will present "Legal Do's and Don'ts: A Defense Attorney's Recommendations on Reducing Liability and Preventing Loss"; and Jere E. Freidheim, M.D., chairman of the Exchange Risk Management Committee, will present "Effective Communication to Reduce Risk and Improve Quality of Care." Call the Chicago Medical Society at (312) 670-2550 for registration forms. ▲

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## **Case in Point: A clarification**

A recent Case in Point focusing on anesthesiology suggested risk management procedures to use when performing a laparoscopy. Several anesthesiologists have indicated that these suggestions may have been ambiguous. The article suggested three steps: monitoring the patient, including use of a Doppler; measuring end-tidal CO<sub>2</sub> when insufflating a patient for laparoscopy; and considering use of a central venous pressure catheter to "bleed out" possible air emboli. Henri S. Havdala, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange Risk Management Anesthesiology Subcommittee, emphasizes that these steps need not be taken when performing all laparoscopies, but only in those instances when the presence of a gas embolism is suspected. ▲

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# Board Briefs

*The Illinois State Medical Society Board of Trustees met Jan. 25 at the ISMS Conference Complex in Chicago. Following are highlights of the board's actions.*

## ISMS to participate in AMA, Gallup survey

ISMS and the American Medical Association will test public opinion on issues of importance to physicians and patients. The AMA Gallup Public Opinion Survey will be conducted nationwide, but in Illinois additional state-specific questions will be asked. ISMS will use the results to formulate policies and public messages on such important health issues as a cap on non-economic damages in malpractice cases, mandatory HIV testing for health care workers, mandatory Medicare assignment, taxation levels and use of advance directives.

## Board approves term limitations

Responding to the 1991 House of Delegates indication of support for limiting board service, the board approved term limitations, including three consecutive three-year terms for trustees, with a maximum of 12 years of service as a trustee. The policy allows trustees seated at the effective date of the change to complete their terms. The president-elect and vice presidents would each serve a single one-year term, and the secretary-treasurer, speaker and vice speaker could serve two one-year terms. These proposed term limitations will be submitted in a resolution that will be considered April 10-12 at the 1992 ISMS House of Delegates annual meeting in Oak Brook. The proposed effective date of the bylaws change is July 1.

## ISMS helps pediatricians provide state services

ISMS and the Illinois chapter of the American Academy of Pediatrics will collaborate to assist the Illinois Department of Public Aid in its efforts to comply with federal requirements to expand state services to children and pregnant women. Due to economic considerations, the state is having difficulty meeting 1989 federal requirements that 50 percent of pediatricians, family physicians or certified nurse practitioners be "full" Medicaid participants, and that Medicaid pediatric rates must be at least 90 percent of the average usual, customary and reasonable amounts of private insurers. The board discussed its history of support for physicians of all specialties, including pediatricians, in areas of legislative advocacy. The board also expressed its continuing concern over the state's trying to meet an increasing demand for services.

## ISMS asks HCFA to continue accepting superbills

ISMS has asked the U.S. Health Care Financing Administration to allow physicians to continue to submit attachments to Medicare claim forms. HCFA announced in November that as of April 1, physicians will be required to complete HCFA-1500 Medicare Part B forms in their entirety and will not be allowed to at-

tach information. This new paperwork "hassle" would affect 36 percent of all Medicare Part B paper claims in Illinois. ISMS also petitioned the AMA to seek relief from this administrative burden on physicians.

## Board strategic planning begun

Breaking into seven discussion groups, the board began a strategic planning process centering on the areas of governmental affairs, membership services, administration and governance, medical education, medical services, health care finance and professional liability. At a future meeting, the board will review a report of the groups' discussions and will assign their proposals to appropriate councils or committees for study and recommendations.

## ISMS to study peer review roles for county and state

The board will conduct a study of the peer review process in Illinois counties and the roles of county medical societies and the state medical society in peer review. Among the pertinent factors surrounding peer review in Illinois are that Illinois is a unified state and, while all membership issues begin at the county level, they must be communicated to the state and national levels. Concerns of the counties include their ability to conduct peer review in a fair manner and the potential litigation and costs that could result from such litigation.

## Fifth fall residency program directors workshop planned

ISMS will hold its fifth residency program directors workshop this fall. The program will feature topics of interest to physician program directors and their administrative staff. In the past, the focus of the workshops has been issues of concern between the Illinois Department of Professional Regulation and residency program directors. While this remains a vital purpose of the program, ISMS benefits from increased visibility and interaction with residency programs in Illinois by hosting the forum.

## FDA interference in CME criticized

The U.S. Food and Drug Administration is proposing unnecessary and duplicative guidelines in the area of drug company-supported continuing medical education activities, according to the AMA and ISMS. In a letter to the FDA, ISMS Board Chairman George T. Wilkins Jr., M.D., reports that organized medicine's accrediting agencies are already implementing stringent guidelines for monitoring and regulating industry-supported activities certified for CME credit. These agencies have implemented stringent guidelines aimed at ensuring scientific integrity and objectivity of CME programming, Dr. Wilkins told the FDA.

## Physician interveners training March 21

ISMS will train new physician interveners in Peoria on March 21. Intervention is the process by which an

impaired physician's family, friends and colleagues confront the physician about the consequences of impairment in a supportive but firm manner. A successful intervention results when an impaired physician agrees to seek treatment and return to a healthy lifestyle. Trained interveners are also protected from civil liability for good-faith actions taken when convincing a physician to suspend medical practice to seek help. An ISMS-produced training film is available free to physicians interested in helping impaired colleagues.

## Society renews efforts to remove MDs from executions

ISMS will continue to work to remove physicians from required participation in executions. The Society will support legislation repealing the state requirements that two physicians witness an execution by lethal injection and that death following execution be pronounced by a physician.

ISMS also will support legislation to allow physicians to file liens on civil cases relative to the treatment of Medicaid recipients; to amend the Good Samaritan law by extending immunity to physicians, hospitals and other facilities for the treatment of patients referred from free clinics; to ensure that Illinois law applies equally to mail-order pharmacies, physicians and pharmacists when dispensing medications; and to allow physicians' liens to be filed in worker's compensation cases and also to require written authorization for release of patient records in such cases. ▲

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## Common questions on the new CPT codes

FOLLOWING ARE some often-asked questions about implementation of the new CPT evaluation and management codes.

### *Why did the AMA change the coding system, anyway?*

Under the old physician payment reform, codes were not specific enough to describe the type of work involved in typical physician-patient encounters and so could not be used with the new Medicare fee schedule, which is based on RBRVS. The new codes are designed in part to reflect the level or degree of medical decision making that goes into a physician's diagnosis, treatment and management options.

The old definitions such as "brief," "limited" and "comprehensive" no longer apply. Physicians and their office staffs should carefully consider all of the relevant evaluation and management code components listed in *CPT 1992*.

### *Is the whole system changing?*

No, only those codes describing office visits, consultations, ER services, initial and subsequent hospital visit services, preventive care and case management services are affected. The old procedure codes numbered 90000-90699 and 90750-90778 have been deleted from *CPT 1992*. The remainder of the Medicine section was moved to the

back of *CPT 1992* but was not renumbered. Except for the typical changes made each year, all other codes remain virtually the same.

### *How do I select a proper code?*

There are several steps to follow in billing a patient visit:

1. First, read the "Evaluation and Management Service Guidelines" in *CPT 1992* and the levels of service descriptions and components.
2. Identify the place of service: Was the visit conducted in a hospital, an ER, a physician's office or other outpatient facility?
3. Identify the appropriate subcategory within the place of service. Was treatment provided to a new or an established patient? Was it an initial or subsequent hospital visit? Was it an initial or follow-up consultation?

4. Determine the extent of the history taken. Was it problem-focused, detailed or comprehensive?
5. Determine the extent of the examination. Was it problem-focused, detailed or comprehensive?
6. Determine the type or complexity of clinical decision making. What were the treatment options? Were there multiple diagnoses? What is the level of risk for complications or co-morbidity? What was the extent of tests ordered?
7. Note how many "key" components are required for using a particular code. If those key conditions are met or exceeded the proper code has been selected.

To obtain a copy of *CPT 1992*, write the AMA Order Department, % 0P0-54192, P.O. Box 10950, Chicago, IL 60610. ▲

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

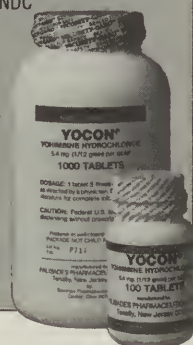
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### **References:**

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## IDPR

(continued from page 2)

taken against physicians "must be based on reasons relating to professional competence or professional conduct."

In a related matter, physicians are reminded that new ISMS-supported legislation signed by Gov. Jim Edgar requires that physicians renewing a controlled substance license register with IDPR for only those locations where controlled substances are stored, said Dunlap. Previously, licenses were required for all locations where controlled substances were prescribed, not just dispensed.

## Hospital merger

(continued from page 2)

four years. The resulting agreement between the two institutions creates the Franciscan United Regional Healthcare System, which officials say will provide a full-service medical center to area residents on two campuses — one in Rock Island, the other in Moline. Inpatient and outpatient services are to be split between the campuses.

The existing Franciscan facility in Rock Island will serve as the system's inpatient hospital on the west campus, housing surgical services, rehabilitation services, a burn center, a cancer center, trauma services and a children's hospital. The existing United facility in Moline will no longer be used. Plans are to replace the United building in three to four years with several additional facilities offering ambulatory and diagnostic services, women's health services and a psychiatric hospital.

Overall, Quad Cities physicians oppose the two-campus plan, Dr. Snodgrass said. Most doctors would prefer to have inpatient and outpatient services available for their patients in one facility, not spread across two cities. "We feel it will be more costly to maintain outpatient services in Moline and inpatient services in Rock Island," he said. "It also poses an inconvenience to the patients and possibly some health risk. Sometimes a physician needs to put an outpatient into the hospital due to unforeseen complications."

Physicians also are criticizing the system's plans to move trauma services from United in Moline to Franciscan in residential Rock Island. Currently, United's Level II trauma center is centrally located near an expressway, Dr. Snodgrass ex-

Finally, Dr. Perez, Vice Chairman Biswamay Ray, M.D., and Secretary Otto Brosius, M.D., were all re-elected to serve second one-year terms as officers of the MDB. In addition, Arvind K. Goyal, M.D., was elected to chair the Illinois State Medical Licensing Board.

All address change notifications should be made in writing and sent to the Illinois Department of Professional Regulation, Licensure Renewal Unit, 320 W. Washington St., Third Floor, Springfield, IL 62786. Additional information regarding medical licensure can be obtained by calling (217) 782-0458. ▲

plained. "The trauma situation is a clear reflection of the absence of physician input in the planning process," he said. "A trauma surgeon would have pointed out [the flaws in the new location] right away."

To address physician concerns, the system is appointing a 12-member Facilities Task Force composed mainly of medical staff members from the two hospitals. The task force is charged with developing recommendations for developing the new facilities and distribution of services between the two campuses.

## Religious traditions play a role

The divergent Catholic and Lutheran religious traditions of the two merging institutions is creating another issue, especially for obstetricians and gynecologists in both cities. The system's consolidation committee has said no elective sterilizations will be performed in the new medical center.

Although "therapeutic sterilizations" will be permitted, Dr. Snodgrass said that term is "vague. It's a play on words, in my opinion." He estimates that 95 percent of sterilizations (tubal ligations, hysterectomies and vasectomies) are elective, and therefore would not be performed. Patients of area Ob/Gyns desiring the procedure would have only one hospital choice — Illini Hospital in Silvis, a nearby suburb.

"Patients who have traditionally gone to physicians [Ob/Gyns] in Moline may now have to go to a physician in Silvis or in Davenport, Iowa, to receive the treatment they want," said Dr. Snodgrass. This could affect other physicians in the Quad Cities, he said. "These patients also could choose to continue medical care for their children and themselves out of our community." ▲



## Bush health care plan

(continued from page 1)

change attributes much of the increase in awards to the non-economic portions of awards.

### Juries unpredictable

The Society has long held that unlimited non-economic awards lead to instability in malpractice insurance, as jury awards become increasingly inconsistent and unpredictable.

"Currently, juries have no guidelines against which to measure the extent of a patient's pain and suffering, making it difficult to attach dollar figures to it," said Dr. Reardon. "As a result, juries' assessments for non-economic damages have ranged from little or nothing to millions of dollars.

"Patients ultimately pay the price through higher physician fees," Dr. Reardon added. "Malpractice premiums add an estimated \$5.6 billion each year to patient bills, while defensive medicine adds another \$15 billion. That's money that could be used more efficiently elsewhere, like preventive care."

In addition to caps, Bush's malpractice reform plan would urge states, through unspecified incentives, to eliminate joint and several liability for non-economic damages and to eliminate double recovery of damages. It also would encourage states to require periodic payments through structured awards, promote

pretrial alternatives and institute new measures to improve quality of care.

ISMS successfully pushed the Illinois General Assembly for similar reforms in 1985 and 1987.

"These reforms have helped reduce the frequency of malpractice suits, but awards continue to climb," Dr. Reardon said. "Without a reasonable cap, the bulging non-economic portion of awards will easily offset these savings."

In addition to malpractice reform, Bush has proposed standardizing health insurance claims to streamline procedures; encouraging expanded use of managed care, such as preferred provider and health maintenance organizations, in both the public and private sectors; and expanding health prevention efforts.

The plan also would grant states greater flexibility in redesigning their health care systems to incorporate innovative cost-containment measures, and improve cost and quality information about providers to help individuals and employers make educated choices when selecting health care.

The president would use the cost savings achieved through these measures to help finance proposed initiatives to expand access to care. Under the plan, families with three or more members below the tax filing threshold would receive tax credits of up to \$3,750 to help them purchase health insurance. Families earning up to \$80,000 would receive comparable tax deductions to help offset the cost of insurance, and self-employed people would be allowed

to deduct 100 percent of the cost of their health insurance premiums.

Bush's plan also calls for health insurance industry reform. Specifically, it would discourage the common practice of "cherry-picking" the profitable, low-risk groups over those at high risk of catastrophic illness; abolish pre-existing condition restrictions for new policyholders; encourage risk pools for small employers; limit state-mandated insurance benefits; and guarantee insurance coverage for the chronically ill.

Finally, in a move away from current antitrust laws, the president would encourage providers to share equipment, through new "safe harbors," to reduce the duplication of sophisticated services. He also would modify the application of antitrust laws to professional peer review. ▲

## 1992 Midwest Clinical Conference set


THE 1992 Midwest Clinical Conference, the Chicago Medical Society's annual educational conference, will school area physicians in how to deal with the unique issues of the '90s. More than 2,000 physicians are expected to attend the three-day meeting, Feb. 29-March 2, at Chicago's Fairmont Hotel.

Seminar topics will include advance directives, violence against women, drug and gang activity in Chicago, and blood-transfusion risks. Physicians also will learn about the latest innovations in pediatrics, plastic surgery, geriatrics, and cardiology, and gain insight into loss prevention and clinical medical ethics.

The meeting's highlights include the presentation of the 15th Annual Public Service Award on Feb. 29. The award honors a Cook County physician for providing outstanding service to the community and the medical profession. The late Robert C. Hamilton, M.D., received last year's award.

The conference's General Session on March 1 features American Medical Association President John J. Ring, M.D., of Mundelein. Dr. Ring will discuss health issues such as national health care, malpractice, and Medicare and Medicaid. For more information about the meeting, contact the Chicago Medical Society at (312) 670-2550. ▲



  
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A black and white portrait of Harold L. Jensen, M.D., an older man with glasses, smiling. He is wearing a dark suit, a white shirt, and a dark tie with light-colored diagonal stripes. The background is dark and out of focus.

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## Canadian health system

(continued from page 1)

sic philosophical principles in their individual health care plans. Now, such funding is provided on a per capita basis. Experts predict that by 1994 health care funding will be left entirely to the provinces.

Costs are generally lower in Canada than the United States, according to Martin Barkin, M.D., a prominent consultant on health care policy and former deputy minister of health for Ontario. "Health care spending per capita in 1987 was \$2,051 for the United States and only \$1,483 for Canada. But in both countries the relative burden per taxpayer is growing at about the same rate," he acknowledged.

Dr. Barkin added that Canada's entire population is covered at a lower total cost than in the United States, where some 37 million are uninsured. This can be attributed to several factors.

"The liability climate in Canada is drastically different from that in the United States," explained Harold L. Jensen, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors and a member of the delegation that traveled to Canada. "There are no contingency fees. Plaintiffs are at risk to pay the defendant's legal costs if they lose. Malpractice trials are conducted by judges – not juries."

Dr. Barkin indicated that the seemingly intractable social problems in the United States directly impact the U.S. health care system.

"Many of the huge social problems affecting the costs of American medicine – violence, drugs, gangs, smoking and the like – are, by comparison, much less pervasive in Canada. Putting a doctor on every corner in our nation – with free access by patients – will not solve our social dilemma," stressed George T. Wilkins Jr., M.D., a pediatrician and current ISMS Board of Trustees chairman.

Another cost factor in the United States is the burden of government and private reviewers looking over physicians' shoulders. "Canada manages cost exclusively through controlling the purse strings," said ISMS President-elect Arvind K. Goyal, M.D. "The government does not in-

trude through PROs, utilization review or other forms of regulatory control.

"Doctors in Ontario say they don't use mammography because of the lack of available equipment, costs and the possibility of false positive results. Because the government reimburses only for hospital-based services, hospitals do not employ innovative, cost-saving outpatient technology," Dr. Goyal continued.

ISMS leadership also visited physicians and hospital administrators.

"We learned that the Ontario Medical Association negotiates with the government on behalf of all physicians in the province," said Dr. Reardon.

The Illinois physicians also sought the views of Roger Hunt, chief executive officer of Toronto's St. Michael's Hospital and former chief executive officer of Lutheran General Hospital in suburban Chicago. "Here in Canada the government is visibly and politically accountable," said Hunt. "It's not like the United States, where the government gives money but doesn't worry about the responsibility of providing care."

Hunt cited, however, one overriding problem with the government being the primary funding source. "In a recession, the squeeze is universal," he said. "Unlike the United States, there are no alternate funding sources in Canada." ▲

## State AIDS program

(continued from page 3)

counseling so that more women could take part in early intervention programs, as recommended in the IDPH guidelines.

Being tested for HIV infection is especially important for women planning pregnancies, Dr. Lumpkin said. If infected, the mother can pass the virus to her baby during pregnancy or birth. Early identification of HIV infection would enable her to seek medical treatment that could help to protect the child.

IDPH has established a toll-free AIDS hot line for information about HIV infection and AIDS. The department will also provide information about testing, which may be free of charge depending on the patient's ability to pay. The hot line can be reached at (800) AID-AIDS. ▲

## Benbennick

(continued from page 1)

known to re-shoot negatives 10 times "because that's what it takes to get the job done properly.

"All too often efforts such as these go unnoticed," said Holden. "But such efforts make a big difference. They say that Rich wants his colleagues' work to look as good as it possibly can, and that he will help any way he can to make sure that it does. Rich doesn't ask for public recognition when he helps our work, and therefore us, look even better."

"The name of our division is Office Services, and the key word is 'service,'" said Benbennick. "We try to help make it easier for you to do your jobs. So, on behalf of everybody in Office Services, thank you very much."

Any full-time, permanent ISMS or Illinois State Medical Insurance Services employee is eligible for the award. Employees can be nominated

by ISMS members or by fellow employees. Employee of the Month criteria require that nominees exhibit innovation and creativity in problem solving, be team players who maximize results and, most important, provide extraordinary service to members, policyholders or internal staff. Recognition can result from either specific efforts on a single project or a consistently high level of performance and service.

"The current selection committee asks that nominations contain specific examples of how the nominee fulfills the criteria," said a representative of the ISMS human resources department, which administers the program. "It's better to err on the side of too much information instead of too little." ▲

*Editor's note: Physicians who wish to nominate a staff member for the Employee of the Month award should request a nomination form from the ISMS human resources department at (312) 782-1654.*

# Anesthesiologists host museum gala

by Tamara Strom

IN CONJUNCTION with Doctors Day 1992, the Illinois Society of Anesthesiologists is marking the 150th anniversary of the first use of ether anesthesia for surgery with a March 6 gala at the Museum of Science and Industry in Chicago.

The gala is a fund-raiser for the anesthesia exhibit at the museum. The exhibit was made possible through the efforts of Illinois anesthesiologists.

Doctors Day traces its roots to Crawford W. Long, M.D.'s first use of ether as a surgical anesthetic in Jefferson, Ga., on March 30, 1842. Today, the medical community celebrates the achievements of all physicians, not just anesthesiologists, as a universal commemoration each March 30. The day is used by medicine as a vehicle to promote public awareness of the profession's contributions to individual communities.

Guests and donations are welcome. For more information about the gala, contact ISA at (312) 263-7150. ▲

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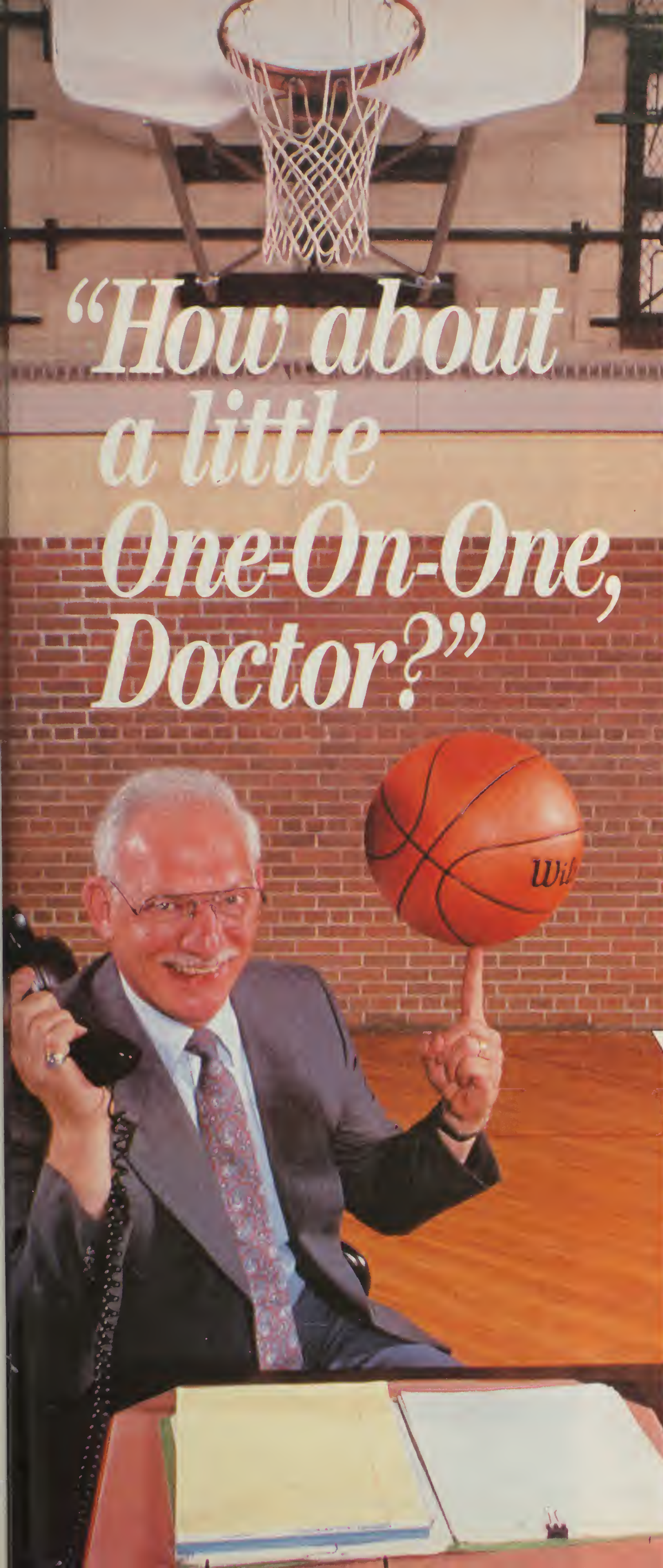
**Continuing medical education: Third Annual Specialty Update,** hosted by the Division of General Internal Medicine, Medical College of Wisconsin. June 24-26, 1992. Location: The American Club resort and Blackwolf Run golf course, Kohler, WI. Course fee of \$360 includes two days of golf. Approved for seven category I CME credits. For registration and information contact: Amy Barnickel, (414) 257-6040.

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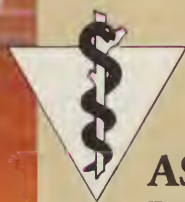
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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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A MILD START IN MILD HYPERTENSION



# Illinois Medicine

UI College of Medicine offers diverse dual-degree program.... 8

March 13, 1992

ILLINOIS STATE MEDICAL SOCIETY



**Physician appointed to Illinois General Assembly**

David Deets, M.D., of Dixon, has been appointed to the Illinois General Assembly. See story, page 3. ▲

## FBI looks into health care fraud

by Tamara Strom

THE U.S. OFFICE of Inspector General will be aided in its efforts to curb fraud in the Medicare and Medicaid programs by several FBI agents who will work as gumshoes for OIG. More than 50 FBI agents will help OIG and other top federal agencies – including the Justice Department, the Food and Drug Administration and Veterans Affairs – crack down on health care fraud.

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*Plaintiffs must secure certificate of merit*

## High court ruling upholds ISMS malpractice reforms

by Tamara Strom

PLAINTIFFS IN medical malpractice cases must obtain a certificate of merit for a lawsuit to be filed, according to a Feb. 20 Illinois Supreme Court decision. The high court ruling upholds tort reforms achieved in the General Assembly in 1985 through a vigorous lobbying and awareness campaign by the Illinois State Medical Society.

"The medical society strongly supported the concept of the certificate of merit during the reform of Illinois medical malpractice laws in 1985 and both the *DeLuna* and *McAlister* cases reaffirm a key measure designed to keep frivolous suits out of our already overburdened judicial system," said ISMS President Robert M. Reardon, M.D. "We recognized

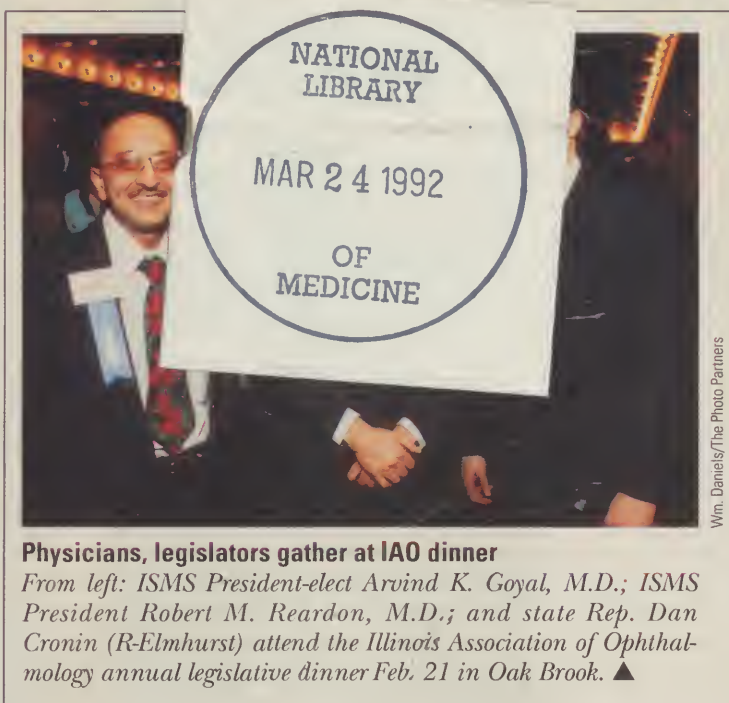


that by weeding out frivolous cases we could help patients who have truly been injured in bringing their cases to the courts."

The Society filed friend of the court briefs in the *DeLuna* and *McAlister* cases, Dr. Reardon said, adding that the Supreme Court's decision is cause for encouragement for physicians. By affirming the constitutionality of the certificate of merit

requirement, the court guaranteed that the progress made in reforming the state's tort system during the past seven years will continue. Prior to passage of the 1985 Medical Malpractice Reform Law requiring a certificate of merit with each malpractice action filed, more than 80 percent of the suits filed in Illinois were closed with no payment to the plaintiff, Dr. Reardon

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**Physicians, legislators gather at IAO dinner**

From left: ISMS President-elect Arvind K. Goyal, M.D.; ISMS President Robert M. Reardon, M.D.; and state Rep. Dan Cronin (R-Elmhurst) attend the Illinois Association of Ophthalmology annual legislative dinner Feb. 21 in Oak Brook. ▲

Win. Daniels/The Photo Partners

*CLIA regs released:*

## Four-year wait yields comprehensive lab rules

by Tamara Strom

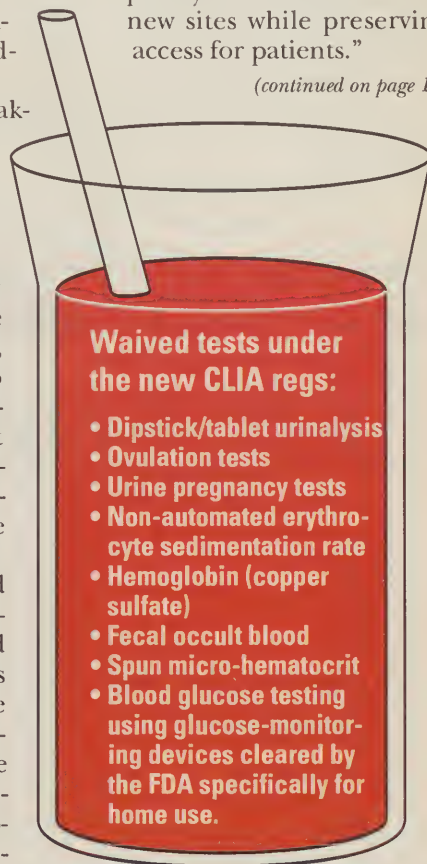
THE DARK cloud of CLIA has arrived. The U.S. Department of Health and Human Services Feb. 28 released the regulations to implement the federal Clinical Laboratory Improvement Amendments.

Four years in the making, the rules will extend federal regulatory authority over 130,000 physician offices nationwide that perform laboratory tests. Draft rules were released two years ago, but were sent back to the drawing board after a storm of protest from the medical community, which blanketed HHS with more than 60,000 letters.

"HHS has pursued twin goals in implementing the law," said HHS Secretary Louis W. Sullivan, M.D. "We must ensure the reliability of tests, and at the same time we must preserve access to laboratory testing for all pa-

tients. HHS agencies have consulted closely with medical and laboratory experts to carry out the law that Congress passed. These rules provide the flexibility necessary to expand federal quality standards to many new sites while preserving access for patients."

(continued on page 17)



## Future residents await arrival of Match Day

by Anna Brown

ALL THE APPLICATIONS have been reviewed and the interviews completed. Now the 1992 candidates for the National Resident Matching Program have ranked their preferred programs and are waiting for March 17 – Match Day.

And while the fourth-year medical students wait, residency programs throughout the country are doing the same. In Illinois, if last year's match results are any indication, many programs can expect to do well.

Cindy LaPorte, the resi-

dency recruitment coordinator for the Rush-Presbyterian-St. Luke's Medical Center obstetrics and gynecology residency program, says that all seven of the program's slots are filled every year.

"It is an extremely popular program," she says. "That's because we're good at what we do." LaPorte mailed 475 sets of application materials last fall, of which she received 265 applications. "The number of requests is growing and growing every year," she says.

Such popular programs

(continued on page 18)

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## News Briefs

### Gov. Edgar appoints new mental health director

Gov. Jim Edgar Feb. 27 appointed Jesse F. McDonald as director of the Illinois Department of Mental Health and Developmental Disabilities. McDonald, who served as director of the Department of Children and Family Services in 1990, has two decades of experience in the delivery of human services.

"Jesse brings tremendous dedication and a wealth of experience in both the public and private sectors to this very important position in my administration," Edgar said. "He has demonstrated throughout his career a commitment to delivering services to the truly needy efficiently, effectively and compassionately."

McDonald is filling the void created when former director William Murphy took advantage of the state's new early retirement incentive program.

Edgar also appointed Cathleen J. Dombrowski as the new inspector general of the department. Dombrowski will be responsible for investigating allegations of patient abuse and ensuring the state's facilities meet the required standards for treatment and care.

"Both Jesse and C.J. have had vital experience in working with those who depend on human services and those who provide them at both the state and community levels," the governor said. "I am counting on them to help our administration develop a comprehensive and visionary network to meet the needs of people who have mental illness and people who are developmentally disabled."

### UI students receive meningitis vaccines

The University of Illinois at Urbana-Champaign Feb. 25 began vaccinating undergraduate students against meningococcal disease. University health officials hope the vaccination campaign, implemented at the recommendation of the U.S. Centers for Disease Control, will halt the in-

stances of the disease on campus. Seven students have contracted the disease since last February.

"We asked CDC to advise us of the best course to follow," said Stanley R. Levy, vice chancellor for student affairs. "Although they told us that the risk of any particular student getting the disease is very low, we wanted to do anything possible to prevent further cases. When we learned that the incidence was reaching a level where vaccination might be an option, we asked CDC for a recommendation."

"Before making a recommendation to vaccinate, the CDC wanted to be certain that the cases didn't arise out of some common link we failed to spot, unlikely as that may have been," Levy continued, adding that five of the cases showed the same strain of the bacterium. "The CDC told us that a variety of substrains or a pattern of direct transmission would have pointed away from this approach, so they were not comfortable making the recommendation until we had eliminated those possibilities."

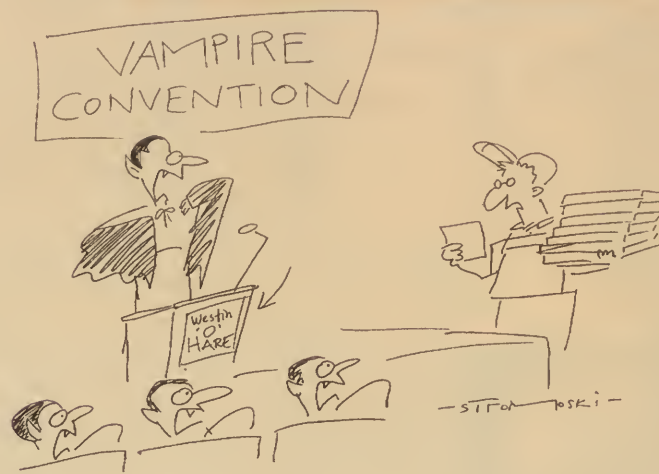
In addition to the CDC, university health officials also consulted the Illinois Department of Public Health, the Champaign-Urbana Public Health District and infectious disease specialists from local hospitals. Area health officials determined the vaccination program will be limited to the UI campus and will not extend into nearby communities.

"Since all but one of the cases have been undergraduates at the U. of I., that group is presumed to be at higher risk for this disease than the general public," said Gale Fella, director of the Champaign-Urbana Health District.

Officials also stressed how rare the disease is in explaining their decision about who will receive the vaccine. "Even at the elevated rates we are seeing in the U. of I. undergraduate student population, the odds of getting this disease are about the same as the odds of being fatally injured in a traffic accident," said Barry Fox, M.D., head of infectious diseases at Urbana's Carle Foundation Hospital and assistant professor of

## ISMS delegates, mark your calendars:

The 1992 Illinois State Medical Society Annual Meeting April 10-12 has been moved to Oak Brook Hills Hotel, 3500 Midwest Road in Oak Brook: (708) 850-5555.



"I've got seven garlic pizzas for an ISMS meeting ... Oops, sorry, wrong place!"

medicine at UI. "Five to 10 percent of healthy adults carry this bacterium in their throats, and in university populations that may approach 20 percent. Carriers are not ill and do not need antibiotics. Vaccination works by boosting immunity, not by getting rid of the bacteria."

### Give your opinion on mail-order pharmacies

With health care costs continuing to rise sharply, many patients are turning to mail-order pharmacies for their medication needs. The Illinois State Medical Society would appreciate physician input about the impact of these mail-order pharmacy houses on health care delivery.

During this year's legislative session, the Society will be lobbying to ensure that Illinois law applies equally to mail-order pharmacies, physicians and pharmacists when dispensing medications.

To ensure that physician concerns about this issue are considered, please call the ISMS Division of Health Care Finance to express your views on mail-order pharmacies at (312) 782-1654 or (800) 782-ISMS. The Society is interested in hearing your experiences with mail-order pharmacies, whether positive or negative.

### Illinois programs, doctors nominated for awards

Five health promotion programs and two physicians have been nominated for the U.S. Department of Health and Human Services 1992 Health Promotion and Community Leadership Awards. Presented every two years, the awards honor outstanding health promotion activities in the 50 states. Winners of the Outstanding Achievement Award and Award of Excellence will be selected by HHS this summer. Illinois nominees are:

- The Will-Grundy Clinic, sponsored by the Grundy County Health Department in Morris. The clinic, staffed by volunteer physicians, nurses and office staff, provides health services to local residents without access to medical care.
- The Comprehensive Perinatal Program of the Crusader Central Clinic Association in Rockford. The program offers comprehensive health care to women and their babies throughout pregnancy, labor, delivery and post-partum.
- Jackson County Wellness Weeks, sponsored by the Jackson County Health Department in Murphysboro. The program reaches more than 1,000 elementary school-age children each year in April with presentations on health and wellness topics.
- The HIV Community Prevention Project of the Cook County Department of Health in Maywood. The program consists of a series of culturally sensitive family workshops on HIV and AIDS prevention in a Hispanic community.
- The Illinois Department of Public Health's Cervical Cancer Control and Demonstration Project. The program developed a computerized patient registry/tracking system and bilingual cervical cancer educational materials at the West Town Clinic in Chicago.
- ISMS member Jerome Klobutcher, M.D., was nominated for his three years of volunteer service at the Cook County Department of Public Health's prenatal clinic in Rolling Meadows.
- ISMS emeritus member Jack Bailen, M.D., a retired pediatrician, was selected for establishing a free clinic in 1988 for Bloomington-area children who do not qualify for public assistance. ▲

— by Tamara Strom

## Physician Facts

### Illinois organ and tissue donations

Organ	1991	1990	Increase
Kidney	341	299	14%
Heart	71	60	18%
Liver	129	100	29%
Lung	23	8	186%
Pancreas	70	48	46%
Heart/lung	3	0	—
<b>Total</b>	<b>637</b>	<b>515</b>	<b>24%</b>
Tissue	1991	1990	Increase
Corneas	950	797	19%

Source: Regional Organ Bank of Illinois, Illinois Eye Bank

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# David Deets, M.D., appointed to the Illinois General Assembly

by Kathy Meyer

WITH THE FEB. 24 appointment of David Deets, M.D., as state representative for the 70th Legislative District, the Illinois House of Representatives now boasts its only physician member.

Dr. Deets, a general surgeon from Dixon, was chosen to fill the unexpired term of Rep. Myron J. Olson (R-Dixon), who died in January. When a vacancy occurs, the Illinois Constitution calls for the county chairmen from the political party controlling the vacant seat to appoint a replacement. The term is up in December of this year.

"It was bittersweet," Dr. Deets said of his appointment. "I was saddened because Myron was a friend. But, I also was excited and honored to be selected."

Dr. Deets announced in January that he would seek the Republican nomination for state representative for the new 73rd District. As a result of the recent redistricting, which is effective for the 1992 election, the new 73rd District includes much of the old 70th District. Dr. Deets is facing Howard "Bud" Thompson of Prophetstown in the March 17 primary.

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*"Having a physician  
in the House of  
Representatives couldn't  
come at a better time."*

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"With health care issues occupying more and more of the legislature's agenda, having a physician in the House of Representatives couldn't come at a better time," said Illinois State Medical Society President Robert M. Reardon, M.D. "There was no physician licensed to practice medicine in all its branches until now."

Dr. Deets said he will bring a physician's perspective to the debate over health care reform. A key element in any reform package, he said, should be expanding access to care. "Morally, it's the right thing to do and it's also very practical," he noted.

Dr. Deets added that improved access to care coupled with an emphasis on prevention will save the state money in the long run. "People sometimes wait until some catastrophe occurs before they get into the system — they wait until they have a heart attack as opposed to finding out they have high blood pressure," he said. "Had these people gotten access earlier, these things could have been prevented and the costs associated with them avoided."

Dr. Deets said he will encourage the state to look beyond the traditional ways to expand access to care. For example, he favors reducing liability for physicians who provide free services to needy patients. This, he said, would expand access by encouraging more physicians to provide charity care.

But Dr. Deets said his first priority in his newly appointed position is to "get the budget balanced so that

people who are owed money are paid money and the state doesn't incur more expenses than it can handle."

Illinois physicians have been hit hard in recent years by the state's budget problems. Physicians have seen Medicaid reimbursements delayed well over 100 days for the majority of the fiscal year. Physicians treating state employees continue to experience a similar problem, as the state currently is taking four months to pay its bills. That is expected to increase to six months before the fiscal year ends June 30.

Higher taxes aren't the answer, Dr. Deets said. Instead, he proposes that

the government "look at places where we can save money."

If Dr. Deets wins election to the House in November, he could play a major role in the debate over additional malpractice reforms — including caps on non-economic damages — if such measures are considered. The Illinois State Medical Society has long supported caps as a crucial step in the effort to control rising health care costs. As a physician legislator, Dr. Deets sees his role in such a debate as a "facilitator to point out to the other legislators how important this is to their constituents."

If potential Republican gains in the legislature materialize, Dr. Deets said, "we have a real good chance" of passing caps. And he predicts that the issue will receive support from manufacturers and product liability groups, since these groups have seen jury awards in product liability cases increase as rapidly as malpractice awards.

In addition to issues affecting physicians, Dr. Deets expressed strong views on education, the economy and the environment.

He said he will urge the state to live up to its constitutional duty to

(continued on page 15)



## Blue Cross Blue Shield

# REPORT

## FOR *Illinois Physicians*

### Blue Shield Supports Your Transition to the Revised HCFA-1500 Claim Form

The Health Care Financing Administration (HCFA) has mandated use of a revised, scannable (12/90) HCFA-1500 claim form effective May 1, 1992 for Medicare B. Blue Shield will accept the revised (12/90) HCFA-1500 claim form and continue to accept and process all current versions of the HCFA-1500 claim form.

Blue Shield encourages you to place your orders for the revised (12/90) HCFA-1500 claim form as soon as possible and will work with you over the next several months as you make the transition to the new form. To assist you, Blue Shield offers you two options:

- Order a "start-up" supply of the revised (12/90) HCFA-1500 claim form by contacting one of our representatives at (312) 938-6187, (312) 938-6269, or (312) 938-6517
- Refer to your February 28, 1992 *Blue Cross Blue Shield Report for Illinois Physicians* for specific instructions on how to order the revised (12/90) HCFA-1500 claim form

#### "Superbill" Update

As published in last November's *Blue Cross Blue Shield Report for Illinois Physicians*, Blue Shield expects that Medicare B will soon eliminate "superbills" as acceptable bills to Medicare. Blue Shield will accept the superbill following the May 1, 1992 elimination of the superbill by Medicare. A study will be conducted to determine an end date for acceptance by Blue Shield based on providers ability to make the transition.

#### 1992 CPT Codes

As a reminder, Blue Shield is supporting your transition to the 1992 Current Procedural Terminology (CPT) codes. As a service to our providers, Blue Shield is accepting the 1991 CPT codes until April 1, 1992.

#### Place of Service Codes

Blue Shield is not currently accepting the new two-digit place of service (POS) codes required by Medicare. Please continue to use the one-digit POS codes until further notice.

(This report is published as a service to the physicians of Illinois.)  
(3/13/92)



## Editorial

## Right on!

**W**hen the Illinois State Supreme Court announced its rulings in *DeLuna* and *McAlister* Feb. 20, organized medicine in Illinois took a giant step forward. Spared a disastrous step backward – had the court ruled the other way – the medical society and its members and the patients they represent strengthened and secured tort reform advances that are designed to reduce non-meritorious suits, while protecting those people who have been truly injured by malpractice.

Both cases focused on the certificate of merit a plaintiff must provide the court attesting to a medical opinion that the allegation of malpractice may have merit. In essence, the certificate, which is signed by a physician practicing in the same specialty as the defendant, notifies the court that the allegations are worth pursuing beyond that point.

The provision's objective is to clear from the court calendar the frivolous suits, the ones that are filed for nuisance value or ones that spring from hurt feelings, rather than from true harm. The fact that Illinois has a law requiring a certificate of merit resulted from the Professional Liability Initiative the medical society mounted in 1985. That year, the legislature took a long and thoughtful look at the law and passed tort reform legislation that, as it happens, was years ahead of its time.

One of the gains made during that initiative, pre-trial screening panels, has since fallen to the court's interpretation. But with the certificate of merit upheld, Illinois physicians and patients can look ahead to the next step – caps on non-economic damages.

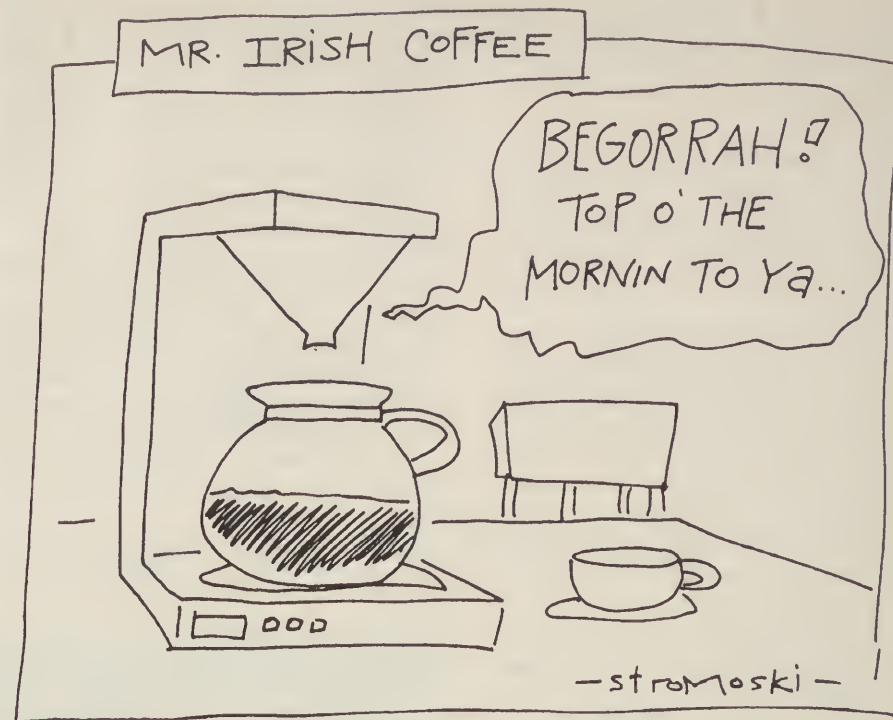
The doctors aren't the only ones looking ahead, however. The self-styled consumer groups the plaintiffs' bar supports so generously are also gearing up on the other side. A recent press release allegedly comparing obstetrical fees and hospital charges for OB patients in Indiana (caps) and Illinois (no caps) came to the dubious conclusion that caps on non-economic awards do not impact on consumer health care costs.

As is usually the case with press releases from these groups, the numbers don't add up. Once again apples were compared to oranges, yielding vague conclusions about hardwood forests.

In and of itself, the release is just another round of small-arms fire. The real war on caps will be fought on that old battleground, Springfield, in that old encampment, the General Assembly. It is there that the issue of caps will eventually be raised again, where it will be argued, debated and decided. Which is why it's all the more urgent that our readers change themselves into voters on March 17 and use Illinois' primary elections to help us make the next step toward tort reform.

The men and women you elect to positions in Springfield will make the decision about caps. President Bush and Gov. Edgar have both come out in support of caps as part of an effective prescription for our health care ailments, nationally and in Illinois. As a result, the debate cannot be far behind.

Do you know where the candidates from your district stand on the issue? Have you done your part in introducing yourself to the candidates, and making yourself available as a source and resource on health care issues – including caps? If not, now is the time to do so. ▲



## President's Column

## What's right about Canadian health care

As I tour Illinois speaking to professional and lay public groups, I am amazed at the amount and degree of misconception that exists about health care systems.

Public support for a "free" national health system, such as that used in Canada, is based on media reports, rather than hard facts. The medical society's recent fact-finding trip to Ontario pointed out a few, little-known facts about the system, including some startling revelations about Canada's system of managing medical malpractice complaints.

In Canada, the liability climate is very different from that in the United States. For many reasons, the litigation explosion that has overwhelmed the American judicial system has not occurred there. What's so different about the Canadian way?

First, there are no contingency fees. Think how instituting this change would impact the legal system in this country. Attorneys in Canada do not collect a percentage of the award. As a result, they are less motivated to file suit after suit, especially when there is little or no basis for them. In America, after all, settling a nuisance suit for \$30,000 is a guaranteed \$10,000 for the plaintiff's attorney.

In Canada, the plaintiffs who sue and who do not receive a favorable ruling are liable for the defendant's legal costs. This again is a powerful motivating factor that makes plaintiffs hesitate. In America, people sue first, often with extreme allegations about deeds or misdeeds calculated to scare the defendant into settling. When the defendant doesn't settle, the plaintiff's attorney sets about looking at the reality of the charges. I predict that we'd see a drastic reduction in the number of suits filed if the plaintiff had to pay the defendant's legal costs if the decision went against the plaintiff.

Another difference is that Canadi-



Robert M. Reardon, M.D.

an malpractice trials are heard by judges, not juries. This removes a potentially volatile factor from the malpractice equation. The "run-away" awards that we too often see are usually the result of an uninformed but sincere jury's misplaced sympathy for the plaintiff.

Still another difference is the existence of a national cap on malpractice awards. Set in the 1970s by the Canadian bench at \$100,000, the cap has been allowed to adjust for inflation to about \$230,000 today. But it is the maximum a plaintiff can collect for malpractice.

Because of these factors, Canadian physicians pay malpractice premiums that are much, much lower than those of their U.S. counterparts. While we cannot duplicate the "Canadian mind-set" regarding malpractice, we can and should take a long, hard look at how the other aspects of Canadian malpractice have helped physicians and patients alike.

Canadian patients may believe they have a "free" health care system. In reality, they "pay" with waits for service, fewer available high-tech procedures and less modern equipment. And they pay with their taxes.

Perhaps it's time that we in the United States shrug off the hidden tax of malpractice. ▲

Robert M. Reardon, M.D.  
President

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## Guest Editorial

## Filtering out all the noise over health care

by Joan Beck

Presidential candidates, George Bush included, will have to have them, if they don't already. Many senators and representatives are flaunting theirs. Dozens more are being floated by medical associations, hospital groups, think tanks and assorted commissions.

A national consensus is building that major changes must be made in our disjointed, excessively expensive, unfair, jerry-built system of health care.

But there is little agreement on whose plan should be tried, how a new system should be structured — and especially who will get stuck with the bills for it.

In sorting through the campaign hyperbole, the self-interested slogans and the do-gooder wishful thinking, voters and taxpayers should resist signing on to any plan until they have satisfactory answers to several critical concerns. A sampling of them:

• *If a proposal calls for a single national health care system run by the federal government, what assurances will the public have that it will work efficiently, caringly and cost-effectively?*

This is the same federal government, remember, that gave us IRS regulations, \$600 Defense Department toilet seats and a national debt approaching \$4 trillion. It's the same government that couldn't or wouldn't stop the savings-and-loan debacle or collect on the lunch chits of members of Congress.

Where would the money come from? Higher tax rates, jeopardizing consumer spending? Taxes on employers, hampering economic growth and job creation? A special employer-employee payroll tax like Social Security? More deficit spending? Is it logical to assume that a combination of price controls, which historically have had disastrous side effects, and bureaucratic decision making can be trusted with such life-and-death matters as health?

• *Who will pay for the free or low-cost health care to be provided for the estimated 31 million to 37 million people who now have no insurance coverage?*

In what are called "play or pay" plans, employers would be required to buy basic health insurance coverage for all employees or pay a per-capita charge into a fund to provide

for all the uninsured.

No one knows how steep such "play-or-pay" payments would become if health care costs keep rising. Or whether employers who are now hurting because of health insurance bills would have to pay still more. Or how many small businesses would simply dump their workers onto the government fund. Or what tax sources would be used to enable the fund to pay for all the uninsured.

• *If a plan calls for everyone to be covered by one of several large, competing, managed care programs, how can patients make sure they will have some control over their treatment?*

Under some of the proposals based on managed care, everyone would be shifted into huge HMO-type groups loosely covering corporations, industries, unions, geographic areas or other associations. In theory, they could hold costs down by regulating how much care each member would get and by pressuring hospitals and physicians for low rates.

But many existing HMOs are having financial problems and are raising rates more rapidly than anticipated. Some patients complain about the difficulties and delays in getting care. And some employers, seeking lower costs, keep shifting workers from one HMO to another, regardless of the doctor-patient relationships that are lost.

• *Will incentives built into a national health care plan to hold costs down jeopardize patients' care?*

Medicaid has held down payments to hospitals so sharply some have had to close. Medicaid fees for physicians are so low some doctors refuse poor patients or run "Medicaid mills." Medicare payments to hospitals have forced the discharge of some patients before it was in their best interests. Now, stricter controls over physicians' fees for Medicare patients are being phased in, worrying the elderly that they, too, may become unwelcome.

• *If a plan calls for "a basic level of care for everyone," what won't be covered?*

This phrase is often used as code for rationing. It usually means the proposal won't cover certain conditions such as infertility or transplants or that it has age limitations or other restrictions.

Some kinds of rationing may seem necessary soon if costs can't be con-

trolled, or may even seem preferable to the tacit rationing of long waits for care under some national health systems. But the public should understand how such a plan intends to shave costs.

• *If a proposal covers long-term nursing home care, does it include reasonable estimates of the cost?*

Millions of disabled elderly are now cared for by their families, often with great difficulties, because they can't afford the \$25,000 to \$50,000 annual bills for nursing home care. No one knows how many of these people would be shifted to nursing homes if a national health care plan were paying the bills.

Every time Congress takes a stab at relieving the burden of nursing

home costs, it gives up in dismay. Demographics show the problem will worsen dramatically in the future, as the population ages.

• *How much more government do we really want in our lives?*

Most of us have already lost some control over our health care. Most of us worry about losing insurance if we change jobs, about our rising deductibles and co-payments, about gaps in our parents' Medicare. We are fair game for politicians promising better. The hard part is being sure what is better before we get stuck with it. ▲

Joan Beck is a columnist for the Chicago Tribune, where this article originally appeared. It is reprinted with permission.

YOCON®  
YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

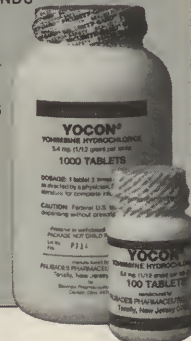
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

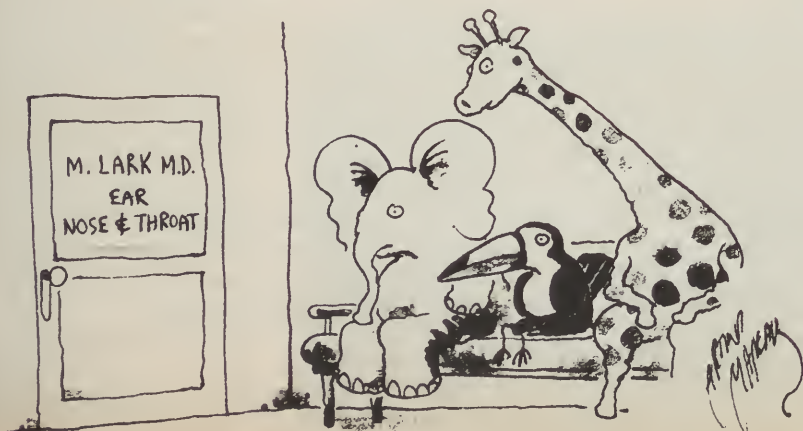
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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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## Guest Editorial

## An evening of support

by James Borgerson, M.D.

Recently, I was invited to attend a program in Springfield for policyholders who had been named a defendant in their first malpractice lawsuit. Sponsored by the Illinois State Medical Inter-Insurance Exchange, "Coping With the Stress of Malpractice Litigation" provided doctors and their spouses with information on the legal process – from being named in a lawsuit through the resolution of the claim, whether it be dismissal, settlement or trial. Through this educational effort, the Exchange hopes to relieve some of the stress experienced by physicians who are



being sued for malpractice.

"Stress" is the operative word. I mentioned that I was "invited" – as opposed to being "qualified" – to attend. That's because today I'm one of the lucky ones. I am not currently experiencing the stress of defending myself in a malpractice suit. But 10 years ago I was. So I know firsthand the stigma associated with being a

defendant in a lawsuit. It implies that we're bad doctors; that we are either incompetent or, at minimum, that somehow we've been negligent. Being sued leaves us questioning our clinical judgment, if not our reason for becoming a physician in the first place. It is a lonely, difficult time.

We also begin to doubt and fear the entire legal process, a process that we have always been taught to believe is weighted toward giving us the benefit of the doubt. Often, however, our only experience with this process is what we've seen on television, which typically reveals only the more theatrical aspects of courtroom proceedings. And we've all read the horror stories of million-dollar verdicts and seen our colleagues become the focus of unfounded negative publicity.

The reality of the situation is much different. As explained by Scott Spooner, a defense lawyer on the seminar's faculty, a trial is actually a well-orchestrated play, where the

players are the lawyers and the audience is the jury. Fortunately, most physicians will never become actors in that play. Less than one in 20 claims ever go to trial. (The good news is that of those that do, 76 percent are won by defendants.)

It is important that physicians who are facing a malpractice suit understand exactly how the legal process works and what is expected of them as a named defendant. The Exchange seminar does precisely that. It explains the role of the Exchange defense team, i.e. the defendant doctor, the Exchange professional liability analyst and the defense attorney. The Exchange's unique "defend or settle" policy and how it works is also examined. And the legal process of discovery and the function of interrogatories and depositions are demystified.

The seminar educates Exchange policyholders in a non-threatening atmosphere that minimizes physician concerns. Questions are asked

## CASE in POINT

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin

## Case #1

**Presenting complaint and initial diagnosis** – A 31-year-old man came to a large group practice complaining of a persistent cough. A primary care physician examined him and diagnosed bronchitis, prescribed appropriate medication and ordered a chest x-ray. The physician told the patient to call for another appointment if the cough continued.

**The case in brief** – A radiologist in the practice read the x-ray and dictated a report expressing concern about it. The report, however, was never relayed to the physician who ordered it. Two weeks later, the patient returned, still complaining of a cough. Another primary care physician in the practice examined him and ordered tests that subsequently ruled out allergy as the cause of the cough.

During the next year, the first physician periodically saw the man, treating him for bronchitis but ordering no further definitive tests to determine the reason for the patient's cough. Fourteen months after the patient was first seen, his cough was worse and he was complaining of night sweats and weight loss. The original physician then ordered x-rays that revealed a mass in the patient's chest; Hodgkin's disease was diagnosed. At this point, the physician located the original chest x-ray interpretation.

**The resulting claim** – The patient sued the treating physicians, the radiologist and the insurance company for delay in treatment necessitating chemotherapy and an autologous bone marrow transplant, which he claimed led to respiratory, gastrointestinal and orthopedic complaints for which he is still being treated. He also alleged that the initial x-rays were improperly handled, and that the radiologist should have immediately recommended further x-rays.

**The outcome of the claim** – The case was settled for \$1.5 million.

## Case #2

**Presenting complaint and initial diagnosis** – A 33-year-old woman had a routine Pap smear done as part of an annual checkup by her family physician. It was sent to a local laboratory for reading.

**The case in brief** – The laboratory reported Class II atypical findings, but the report was inadvertently placed directly into the patient's chart and never seen by the physician. Eleven months later, the woman returned to the office with complaints of vaginal bleeding. The physician ordered another Pap smear, which showed Class III atypical findings with dysplasia. Cervical cancer was diagnosed and the patient underwent surgery, extensive chemotherapy and radiation. Complications from the radiation necessitated a colostomy.

**The resulting claim** – The patient filed a negligence suit alleging delay in diagnosis and treatment resulting in significant reduction of her life expectancy.

**The outcome of the claim** – The case was settled for \$250,000.

## Case #3

**Presenting complaint and initial diagnosis** – A 64-year-old woman was being treated by a cardiologist for congestive heart failure, paroxysmal atrial flutter and a left bundle branch block. She had received a pacemaker a year earlier. She called

her cardiologist one morning saying she was dizzy and nauseated and was vomiting.

**The case in brief** – A medical assistant in the cardiologist's office told the woman the cardiologist was on vacation but that another physician was covering his patients and would return her call shortly. The message was relayed to the covering physician. Hours went by and the woman made two more calls to the office, but the covering physician never returned her calls. She died that evening from ventricular arrhythmia.

**The resulting claim** – The woman's family sued both cardiologists for negligence in failing to respond to her repeated calls, for patient abandonment and for wrongful death because of delay in treatment.

**The outcome of the claim** – The covering physician argued that the woman never expressed urgency when she repeatedly called the treating cardiologist's office and spoke to the medical assistant. She was, however, wearing a Holter monitor the day she died, which showed she was developing a severe heart problem. The monitor's tracings were obtained by the plaintiff's counsel. The case was settled for almost \$100,000.

**The points these cases make** – All the above cases illustrate medical office system failures that can precipitate hard-to-defend liability claims, suggests Vasanth Surath, M.D., a Chicago internist and member of the Illinois State Medical Inter-Insurance Exchange Risk Management Committee.

"These things can happen," says Dr. Surath. "The system breakdowns in the first two cases are more common in group practices in which a number of physicians are involved in a patient's care, but they can occur in a solo physician's office as well. Consequently, every medical office, and especially an office with more than one physician, should have specific systems for handling patient information, results of laboratory tests and x-rays, and telephone calls."

The Exchange offers the following suggestions to minimize the possibil-

ity of communications system breakdowns that could lead to a claim:

- Every office should develop a fail-safe follow-up system for all tests ordered.
- The physician should read and initial all test reports before filing.
- Immediate follow-up, including scheduling another appointment for the patient, should be ordered when a lab report with abnormal results is received.
- When more than one physician or consultant is involved in diagnosing and treating a patient's problem, extra efforts should be made to assure that all involved share necessary information.
- An effective system for triaging phone calls to a medical office should be established and personnel trained to recognize and respond quickly to emergency calls.
- If a physician arranges for practice coverage, he or she should ensure that the covering physician will respond to patients' needs in a timely fashion, especially in the event of an emergency.

Dr. Surath emphasizes the importance of the physician personally communicating a patient's test results to the patient. "Patients today have high expectations of physicians," he says. "One of these expectations is that when a physician orders various tests, he or she will personally communicate those results. When a physician doesn't do so, patients may construe this to mean that they are not receiving the highest quality medical care. So a physician should make every effort to discuss test results in a timely fashion with patients."

"It is the patient's personal physician, not a member of the medical office staff, who ultimately is responsible for a patient's care and who will be held liable if something goes wrong," stresses Dr. Surath. "Consequently, the physician is required to develop and maintain systems in the medical office that will minimize the possibility of slipups that could jeopardize a patient's care and lead to a liability claim." ▲

Carol Brierly Golin is publisher of Medical Liability Monitor.



and answered in a supportive environment. Participants learn as much from the questions posed by their fellow attendees as from the "experts" on the panel. The panel members, in turn, leave the impression that they are part of team, not just detached educators.

My case has been closed for 10 years. My only regret is that I didn't have this kind of support then. It would have made my experience so much easier. Current policyholders, however, can take advantage of this outstanding program. The seminar, retitled "Taking Control: Managing Your Malpractice Suit," will be repeated May 6 at the Lincolnshire Marriott in Lincolnshire, Sept. 9 at the Oak Brook Hyatt in Oak Brook

and Oct. 21 at the Collinsville Holiday Inn in Collinsville. The seminar is free of charge and open to Exchange policyholders and their spouses. Registration information can be obtained by calling (312) 782-2749 or (800) 782-ISMS.

I strongly urge all Exchange policyholders — whether currently under the threat of litigation or not — to consider "inviting" themselves to one of the upcoming seminars. I can personally attest that you will experience an evening of enlightenment and support. ▲

*Dr. Borgerson, a general practitioner from Mt. Pulaski, is a member of the Illinois State Medical Inter-Insurance Exchange Board of Governors.*



"Probably I needn't be so superstitious, but I just don't take new patients whose first name is 'Sue.'"

#### Zantac® 150 Tablets (ranitidine hydrochloride) CONDENSED BRIEF SUMMARY

Zantac® 300 Tablets  
(ranitidine hydrochloride)  
Zantac® Syrup  
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

**INDICATIONS AND USAGE:** Zantac® is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy and is maintained throughout a 6-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS: General:** 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

**Laboratory Tests:** False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

**Drug Interactions:** Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

**Pregnancy: Teratogenic Effects: Pregnancy Category B:**

Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arrhythmias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocellular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Although controlled studies have shown no antitumor activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

**OVERDOSAGE:** Information concerning possible overdosage and its treatment appears in the full prescribing information.

**DOSAGE AND ADMINISTRATION:** (See complete prescribing information in Zantac® product labeling.)

**Dosage Adjustment for Patients with Impaired Renal Function:** On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

**HOW SUPPLIED:** Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54). Store between 4° and 25°C (39° and 77°F). Dispense in light, light-resistant containers as defined in the USP/NF.

September 1991

**Glaxo Pharmaceuticals**  
DIVISION OF GLAXO INC.  
Research Triangle Park, NC 27709

Zantac® Syrup:  
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ZA2407 Printed in USA January 1992

# Zantac® Tablets

ranitidine HCl/Glaxo 150 mg tablets bid

# WHEN ACID REFLUX ERUPTS

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# UI College of Medicine at Urbana-Champaign offers diverse dual-degree program

by Anna Brown

THE UNIVERSITY of Illinois College of Medicine at Urbana-Champaign forms the final link in the UI medical school branch system. Under the direction of Charles C.C. O'Morchoe, M.D., Ph.D., D.Sc., the College of Medicine boasts a Medical Scholars Program unique to the Midwest.

Situated on the main university campus, its doors are open to medical students who wish to pursue diverse academic study.

"We have the largest dual-degree program in the country, and certain-

ly the most diverse," says Dr. O'Morchoe. The program features almost 40 disciplines students may select, in addition to medicine.

The Urbana-Champaign medical program has three components, says Dr. O'Morchoe. It provides a one-year basic science program for students who will complete their M.D. degrees at either Rockford or Peoria. A few of these students, however, remain at Urbana-Champaign to complete a medical degree. The remaining 140 students participate in the Medical Scholars Program, concurrently working toward an M.D. and a doctorate in a separate discipline.

A lymphologist who came to Urbana in 1984 via the chair of the Loyola University Stritch School of Medicine anatomy department, Dr. O'Morchoe says that most medical school dual-degree programs offer a Ph.D. in one of six biomedical sciences. "We offer a much wider range, including the humanities and the social sciences as well as the hard sciences," he says.

"One of the advantages of our program is that we offer a very large degree of flexibility for students to tailor their programs to their individual needs," adds Dr. O'Morchoe.

The Medical Scholars Program was formed when the College of Medicine initiated its clinical curriculum in 1978. From 1971 until 1978, the college was a school of basic medical sciences.

"Students study for an M.D. and a second degree, by and large a Ph.D., but we also have some students studying for a J.D.," he says. Dr. O'Morchoe describes Medical Scholars students as "very diverse and talented." Completing the seven- to eight-year program is "quite an undertaking," he says.

## Hooked on academics

In 1984 when Dr. O'Morchoe came to Urbana, the clinical program was still young. A native of Ireland, he earned his M.D. from Trinity College in Dublin in 1961, where he also taught basic science for a year and became "hooked on academic medicine." His first faculty position was in Dublin from 1957 to 1961.

"If you are following an academic career in Britain or Ireland, there is one degree you have to have," says Dr. O'Morchoe. "It's called BTA, or 'been to America.'"

In 1961, he taught for a year at the University of Maryland in Baltimore and at Harvard as a visiting instructor in the anatomy department. He then returned to the anatomy and physiology department at Trinity for five years. He rejoined the Maryland anatomy department in 1968, where he stayed until he accepted the Loyola Stritch position in 1974. Dr. O'Morchoe earned his Ph.D. in 1969 from Trinity.

Dr. O'Morchoe has served as president of the North American Society of Lymphology, and is currently president-elect of the International Society of Lymphology. He has been active in the American Association of Anatomists, for which he edited two journals and served as director of its placement service for 10 years.

Being located on the main UI cam-

pus is an "enormous benefit to the medical school," says Dr. O'Morchoe. "We also believe that it is a great benefit to this campus to have the medical school here. Without [being on campus] the Medical Scholars Program would not be possible."

He says he would like to see even further collaboration with other areas of the campus in the future.

"What I would regard as a major target of the College of Medicine on this campus is to provide the medical link for faculty who are outside of the medical school, who are doing research in areas that clearly have medical or clinical application," he says. "There are many of them in engineering, for example, in nutrition, in psychology, in health and safety studies."

"I see this happening slowly," Dr. O'Morchoe continues. "I know it could happen a lot faster if the budget situation wasn't so gloomy."

In his eight years at UI, Dr. O'Morchoe has overseen considerable changes in the medical school. He has seen growth in the size and prestige of the Medical Scholars Program, which received 130 applications to the program last year, of which 25 were accepted.

*"The most important thing in a general education at the present is for students to get a broad background in medicine as it is practiced today."*

"The dual-degree program is much better known and has developed a reputation across the country," he says.

Since 1984, Dr. O'Morchoe says six clinical departments have formed and developed their faculty and programs. While the college uses about 400 community physicians as faculty, very few are full-time clinical staff members. The clinical education program itself has developed significantly, including a heavy emphasis on ambulatory care medicine.

The program offers medical students greater opportunities for personal and educational interactions with attending physicians, rather than residents, he notes. "This is partly because we don't have that many residents, and partly because we strongly encourage the interactions in direct teaching of practicing clinicians with students."

First-year medical students, for example, are encouraged to select an M.D. adviser. Some choose to work



Charles C.C. O'Morchoe, M.D., Ph.D., D.Sc.

with a community physician, spending a few afternoons observing his or her work in the office environment. This way students can "see patients right from the beginning and learn something about the practice of medicine," says Dr. O'Morchoe.

"The most important thing in a general education at the present is for students to get a broad background in medicine as it is practiced today," he continues. "It's important that our students see the entire level of medical care from primary care with the general practitioner through to tertiary care within the hospital."

## Need for rural health care

Like its sister campuses in Peoria and Rockford, the Urbana-Champaign branch of the University of Illinois medical school system is taking responsibility for imparting the importance of rural health care to its students, says Dr. O'Morchoe.

"There is no question that Urbana-Champaign is a rural community," he adds. "Rural health care is becoming a major focus within the state, and is something we are very concerned with."

Dr. O'Morchoe says that while the medical scholars are being trained as academic leaders and often do not study rural health care, there are opportunities for other students to become fully acquainted with rural health care. Residencies are available in a new family practice program at Carle Foundation Hospital in Urbana, and the college is also collaborating with Carle Clinic and the hospital to find ways to play a more significant role in rural health care.

"The intent and hope is that many of the graduates from [the residency] program will stay in central Illinois, or at least in Illinois," he says.

Dr. O'Morchoe describes the medical school program as "interesting because it is different. It is different in its main thrust, different in its association with hospitals and clinics, and different in its association with this campus." ▲

*This is the last in a series of articles profiling Illinois medical school programs and deans.*

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April 25 - May 1, 1992
- ☐ Advances in Surgery  
April 27 - May 1, 1992
- ☐ Specialty Review in  
Obstetrics and Gynecology  
May 2 - 8, 1992
- ☐ Specialty Review in  
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# IMPAC annual meeting April 10 at Oak Brook Hills Hotel

THE ANNUAL MEETING of the Illinois State Medical Society Political Action Committee (IMPAC) will take place Friday, April 10, at the Oak Brook Hills Hotel. The meeting, open to all IMPAC members, will convene immediately following the Illinois State Medical Society's House of Delegates morning session.

Business will include election of IMPAC Council members. Nominees for appointment or reappointment to the council are: David B. Littman, M.D., Highland Park; Patrick F. (Paul) Mahon, M.D., Springfield; George T. Mitchell, M.D., Marshall; Palmalea Taylor, Danville; Robert M. Vanecko, M.D., Chicago; George T. Wilkins Jr., M.D., Edwardsville; Reynold J. Gottlieb, M.D.,

Oak Brook; Mary Ann Stoffel, Moline; Richard A. Quinones, M.D., Chicago; Terry Mason, M.D., Chicago; and Dennis M. Brown, M.D., Schaumburg.

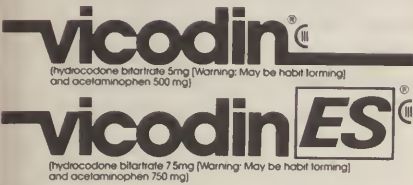
In addition, IMPAC members attending the meeting will discuss and vote on the following amendment to the organization's bylaws:

*Article IX – Nomination and Election of Members of the Council is hereby amended by adding Section 6.*

*Section 6. Vacancies on the IMPAC Council, either Officer or Council member, shall be filled pursuant to appointment by the IMPAC Chairman. Any Officer appointed by the Chairman shall be a current IMPAC*

*Council member. Any Council member appointed by the Chairman shall be a member of the Illinois State Medical Society and a contributor to IMPAC. All appointments shall be made with consideration given to a geographical distribution of the Council membership. An Officer or Council member appointed shall serve the remainder of the unexpired term of the Officer or Council member he/she replaces.*

*In the event of a vacancy in the office of the Chairman, the First Vice Chairman shall serve as acting Chairman until the first meeting after the next annual meeting of IMPAC. The acting Chairman shall assume all duties and responsibilities of the Office of Chairman. ▲*



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

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WARNINGS:

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.



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	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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1. Data on file, Knoll Pharmaceuticals  
2. Standard industry new prescription audit



# Residents fight Congress for flexibility of loan deferments

by Tamara Strom

THE NATION'S RESIDENT physicians and medical students are embroiled in a fierce battle with Congress over the lawmakers' intention to eliminate deferments for medical school loans. The Senate voted last month to put an end to deferments and a bill still pending in the House threatens to do the same. If Congress gets its way, resident physicians will be forced to begin paying back their student loans before they complete their training or start racking up additional interest by putting their loans into forbearance.

"This is the top priority issue for residents," said Marc A. Duerden, M.D., chairman of the Illinois State Medical Society Resident Physicians Section and a resident in physical medicine and rehabilitation at Northwestern Memorial Hospital in Chicago. "This is the RBRVS for resident physicians."

The Congressional action is part of the reauthorization of the Higher Education Act that governs federal loans and grants to graduate-level students, including those in medical school. Lobbying efforts are ongoing in an attempt to convince lawmakers to defeat the House bill. Resident physicians have been targeting key

members of Congress to express their concern about the potential end to loan deferments.

Dr. Duerden calls the bills "short-sighted," saying Congress is considering cutting deferments to fund other areas of education. "It's the typical response of a budget-cutting Congress."

Under current law, residents are allowed two years of deferment, during which the government picks up the tab on their interest payments. After residents use up their deferment, they must go into forbearance if they still cannot afford to make the installments on their loan. When a student loan goes into forbearance,

the resident pays the interest that accrues, not the government.

An earlier version of the Senate bill had even threatened to cut out the option of forbearance for residents. "To eliminate forbearance would not have any positive budget implications," Dr. Duerden said. "The bank is going to get its money."

Residents around the nation have galvanized support within the ranks of organized medicine to help in the fight. The American Medical Association's Resident Physician Section put the deferment issue at the top of its agenda during the recent AMA interim meeting in Las Vegas.

At issue is a resident's ability to pay the hefty loan payments incurred while in medical school. It is not unusual for a resident to have accumulated about \$42,000 in debt when he or she begins residency training, Dr. Duerden explained. "Many residents face monthly payments of \$500 to \$1,000 at a time when they are only making \$25,000 a year," he said.

## ISMS program offers deferment

ISMS has long been a proponent of student loan deferments, offering the option to all physicians who take out loans through the Society's loan program. "My concern is that when students finish medical school they are only partially trained," said Fred Z. White, M.D., a family physician from Peoria who instituted the ISMS loan program a decade ago. "Physicians' income doesn't really come in until they have finished their residency training. All we are asking is that Congress allow residents to defer their payments just that long — until they have completed their education and training."

Dr. White contends that the success of the Society's loan program is based in part on the deferment policy. In some specific instances, physicians are permitted to defer their payments past the time they enter practice. Yet despite this leniency, or perhaps because of it, the program boasts a zero default rate, he said.

"We're not pressing them when they're against the wall," he said. "My hope is that nationally you'd have less default than if you insist on payment too early and too soon. If you wait until after residents are making more appropriate incomes for their educational level there will be a much better chance of the doctor paying the loan on schedule."

Dr. White added, however, that even once a physician begins practicing, the significant debts incurred during medical school still loom large. "Many physicians are choosing to join group practices, but the trouble is they want a guaranteed income level because of their loans," he said. "We must find some way to bridge that gap."

Dr. Duerden said losing the options of deferment and forbearance could ultimately limit access because many talented and skilled individuals would not be able to afford to go to medical school. "An economic selection process will be taking place," he said. "Because of economic hardship of some form, many qualified people won't be going to medical school — the people who don't have mom and dad who can afford to pay their way through school." ▲



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# Vaccinate your employees properly against HBV

by Tamara Strom

WITH A FEDERAL mandate looming for employers to provide the hepatitis B vaccine to all workers with an occupational risk of exposure to the virus, physician-employers should ensure their workers receive the HBV vaccine properly. The U.S. Centers for Disease Control is warning health care organizations that some employees and patients are being vaccinated with unapproved methods.

According to the CDC, some employees are receiving a low-dose intradermal version of the HBV vaccine instead of the approved intramuscular injections. While the intradermal vaccine is currently being studied, it has not yet been approved by the U.S. Food and Drug Administration. The CDC reports that many people fail to develop sufficient antibody levels to establish immunity against HBV following intradermal vaccinations.

The "hepatitis B vaccine [should] be administered by the intradermal route only when a research protocol is used that includes informed consent from vaccinees and post-vaccination antibody testing to detect non-responders who would then be eligible for revaccination," the CDC said in a recent edition of *Morbidity and Mortality Weekly Report*. "Moreover, intradermal vaccination programs offered by private contractors do not offer substantial cost savings over intramuscular vaccination and may fail to induce immunity in a substantial proportion of vaccinees. For these reasons, vaccination programs should not use the intradermal route of administration."

## OSHA rules call for vaccine

Physicians whose employees have an occupational risk of exposure to HBV must offer the vaccine to their workers free of charge, according to final rules on transmission of blood-borne pathogens issued in December by the U.S. Occupational Safety and Health Administration. The OSHA regulations went into effect March 5 and established staggered deadlines for employer compliance.

OSHA set a July 6 deadline for physician-employers to begin vaccinating workers against HBV. In setting the deadline, the federal regulators allowed for the HBV vaccination regimen that calls for three shots over six months. As long as a worker who wants the vaccine has received the first injection in the series by July 6, the employer will be in compliance with the statute. Employers who do not comply with this and the other OSHA rules governing transmission of bloodborne pathogens face stiff monetary penalties.

Workers who decline to receive the vaccine have the legal right to do so, but must sign a waiver indicating their decision not to be vaccinated. Physician-employers must keep these waivers in the workers' health and personnel files. If the employee changes his or her mind at any time and decides to receive the vaccine, the employer must provide it without any cost to the worker.

The CDC also recommends post-vaccination antibody testing for all health care workers who are at risk for "percutaneous or permucosal exposure," even though this testing may add to the overall cost of a testing program. Workers with a "lower" occupational risk for contracting the virus would not need the post-vaccine testing, the CDC said.

The agency also said the vaccine does not replace the need for health care workers who come in contact with blood or body fluids to use universal precautions with all patients. ▲

## Texas Medical Association clarifies CME credit

THE TEXAS MEDICAL Association has notified state medical societies that a nationally distributed brochure erroneously identifies the TMA as providing Category 1 CME credit for board review courses provided by the Osler Institute in Indiana. The following is the TMA statement:

*The Texas Medical Association is in no way associated with any 1992 board review courses conducted by the Osler Institute of Terre Haute, Ind., and has not designated these activities for any type of CME credit of the Physician's Recognition Award of the American Medical Association.*

*Physicians with questions or concerns about CME credit for 1992 board review courses which carry the Texas Medical Association's CME accreditation statement should contact: Carrie Laymon, TMA Medical Education Department, 401 W. 15th Street, Austin, TX 78701-1680; (512) 370-1446. ▲*

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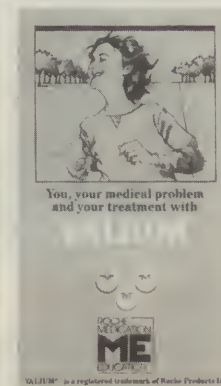
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member of the EIU President's Club and Panther Club. During his tenure at EIU, Dr. Heath assisted in developing instructional curricula for athletic trainers and helped initiate the psychological counseling center, the medical technology program and medical insurance for EIU students.

**Ian C. MacLean, M.D.**, of Chicago, was installed as president of the American Academy of Physical Medicine and Rehabilitation. Dr. MacLean has been a member of the organization since 1967, and has served on the Board of Governors since 1986. He is an attending physician at the Rehabilitation Institute of Chicago and Northwestern Memorial Hospital in Chicago. Dr. MacLean is also an associate professor of clinical physical medicine and rehabilitation at Northwestern University Medical School. ▲



## New HMSS governing council elected

The Illinois State Medical Society Hospital Medical Staff Section elected new governing council members at its annual meeting Feb. 8 in Chicago.

Front row, from left: Thomas C. Malvar, M.D.; A. Rashied Shedbalkar, M.D.; Charles R. Frazer Jr., M.D.; and Treasurer John F. Schneider, M.D.

Back row: Charles Drueck III, M.D. and Secretary Richard A. Schmidt, M.D. These new members will serve until 1994. ▲

Photo: Wm. Daniels/The Photo Partners

## BuSpar® (buspirone HCl)

**References:** 1. Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology*. 1989;21:124-130. 2. Newton RE, Maruncz JD, Alderdice MT, Napolitano MJ. Review of the side-effect profile of buspirone. *Am J Med*. 1986;80 (suppl 3B):17-21. 3. Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med*. 1987;82 (suppl 5A):20-26.

**Contraindications:** Hypersensitivity to buspirone hydrochloride.

**Warnings:** The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

**Precautions:** **General—Interference with cognitive and motor performance:** Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable, therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

**Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients:** Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

**Possible concerns related to buspirone's binding to dopamine receptors:** Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

**Information for Patients—**Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone, to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone, to inform their physician if they are breast feeding, and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

**Drug Interactions—**Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations on SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

**Carcinogenesis, Mutagenesis, Impairment of Fertility—**No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed, chromosomal aberrations or abnormalities did not occur.

**Pregnancy: Teratogenic Effects—**Pregnancy Category B. Should be used during pregnancy only if clearly needed.

**Nursing Mothers—**Administration to nursing women should be avoided if clinically possible.

**Pediatric Use—**The safety and effectiveness have not been determined in individuals below 18 years of age.

**Use in the Elderly—**No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

**Use in Patients with Impaired Hepatic or Renal Function—**Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

**Adverse Reactions (See also Precautions): Commonly Observed—**The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

**Associated with Discontinuation of Treatment—**The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

**Incidence in Controlled Clinical Trials—**Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: **Cardiovascular:** Tachycardia/palpitations 1%, CNS: Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%, **EENT:** Blurred vision 2%, **Gastrointestinal:** Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%, **Musculoskeletal:** Musculoskeletal aches/pains 1%, **Neurological:** Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%, **Skin:** Skin rash 1%, **Miscellaneous:** Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

**Other Events Observed During the Entire Premarketing Evaluation—**The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. **Cardiovascular—**frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. **Central Nervous System—**frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. **EENT—**frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. **Endocrine—**rare: galactorrhea, thyroid abnormality. **Gastrointestinal—**infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. **Genitourinary—**infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. **Musculoskeletal—**infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. **Neurological—**infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. **Respiratory—**infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. **Sexual Function—**infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. **Skin—**infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. **Clinical Laboratory—**infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. **Miscellaneous—**infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

**Postintroduction Clinical Experience—**Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

**Drug Abuse and Dependence: Controlled Substance Class—**Not a controlled substance.

**Physical and Psychological Dependence—**Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

**Overdosage: Signs and Symptoms—**At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

**Recommended Overdose Treatment—**General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

U.S. Patent Nos. 3,717,634 and 4,182,763

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▲ More commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%)

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## Progressive Relief of Persistent Anxiety.



It's "business as usual," said OIG spokesman Judy Holtz of the additional agents working on Medicare and Medicaid fraud investigations. "There is no one particular area that is being targeted," Holtz said. "The FBI putting these additional resources into health care is good. They can get at things that we can't because they have broader jurisdiction."

By and large, most physicians are "very honest and hard working," Holtz added. "Like in anything, a few bad apples spoil it for everyone."

But some in the medical community are concerned about the appearance of the FBI becoming involved in fraud investigations. "The FBI entrance into the OIG's policing efforts sends a disturbing message to the public that fraud is rampant in the Medicare and Medicaid programs," said Illinois State Medical Society President Robert M. Reardon, M.D. "By the government's own admission, most physicians are hard working and honest. All of our members want fraudulent practices stopped; we just don't think it's widespread or serious enough to bring in the FBI."

With eyes in Washington turned toward holding down spiraling costs

in the bulging federal health care programs, fraud is an obvious place to start. "We certainly appreciate that everybody needs to work in cleaning up the health care area," Holtz said. "Health care fraud is definitely costly to the system."

The government has seen an increase in health care fraud during the last decade, Holtz said. For example, the 25 criminal convictions for fraud in the health care realm in 1981 grew to more than 100 such convictions in 1991. Only 91 providers received administrative sanctions from OIG in 1982, but 1,005 were sanctioned in 1991. This dramatic rise is due in part to the increase in enforcement responsibilities Congress has given to OIG.

"We're getting better at identifying fraud, and Congress has given us broader authority to go after offenders," Holtz said.

OIG has the authority to seek criminal convictions or levy civil monetary penalties and administrative sanctions, such as exclusion from participating in government health care programs. OIG concentrates more on civil actions than criminal actions because a civil sanction is as effective as criminal proceedings in removing offending providers from the program, according to OIG. For example, providers can be assessed

Administrative sanctions and civil monetary penalties as recorded in semiannual reports, 1983-1991

FY	Number of settlements	Number of sanctions	Amount†
1983	6	230	\$ 1,474,100
1984	83	327	\$ 7,648,717
1985	70	390	\$ 9,755,911
1986	110	412	\$ 9,269,301
1987	79	440	\$11,678,921
1988	95	466	\$12,522,916
1989	104	846	\$14,920,253
1990	76	900	\$15,978,624
1991	70	1,005	\$26,772,788

†Includes base settlement amount and interest.  
Source: HHS/OIG Office of Investigations.

finest of several thousand dollars for each fraudulent claim.

"A major objective of OIG's investigation and enforcement functions is to obtain criminal convictions and restitution from health care providers and suppliers who commit fraud against Medicare, Medicaid and other health care programs," according to an OIG report on health care fraud from 1987-1991. "Another significant objective is to stop them from doing business with the government, thereby eliminating undeserved payments."

Patient dumping investigated

Among the areas OIG is currently investigating are hospital and physician patient dumping, upcoding for higher reimbursement, kickbacks for referrals and services, physician-chiropractor billing arrangements, anesthesiologist false time increments and laboratory services fraud. False billing and billing for services that were never rendered are growing areas of fraud in the government-run health care programs, Holtz said.

"It's happening across the board with Medicare and Medicaid," she noted. "It's in all areas across all specialties. And it's not only physicians; it's nurses, hospital administrators, ambulance companies, durable medical equipment [suppliers], pharmacists and dentists. I don't think any specialty is worse than the others."

Physicians also can be sanctioned by the Medicare and Medicaid programs for failure to repay student loans and if a medical licensing board revokes their license for any reason. OIG also is continuing its investigations of possible violations of the recent "safe harbor" or anti-kickback regulations pertaining to legal joint ventures and referrals.

"The OIG is concerned that kickbacks, whether spelled out or implied, are more than technical violations of the law," the government's fraud report states. "They can harm patients. In many cases, the doctor has a financial incentive to send sick people to the facility that gives the best deal, not the one that gives patients the best care."

The government also is cracking down on providers who illegally waive co-payments for their Medicare patients. For example, if Medicare's "reasonable charge" for a service is \$100, the beneficiary must pay \$20 of the doctor's bill for Medicare to pay \$80.

"The routine waiver of deductibles and co-payments under Medicare Part B of Medicare results in false claims, violations of the anti-kickback statute, and excessive utilization of items and services paid for by Medicare," according to OIG. "The Medicare deductible is the amount that must be paid by a Medicare beneficiary before Medicare will pay for any items or services for that individual. Despite the appearance that routine waiver of fees benefits Medicare beneficiaries, it does not. It is simply a device to generate business."

Holtz said the government is concentrating on health care fraud because of the large amounts of money providers could potentially scam from the system. She explained that providers who cheat the system have become more sophisticated in devising schemes. "The more loopholes you close, the more ways they find to get around it." ▲

Monetary returns from Medicare/Medicaid cases, 1985-1991

(Dollars in millions)

FY	Medicare			Medicaid
	Investigative receivables*	Savings	Total	Total
1985	\$12.6	\$ 8.3	\$20.9	\$ 7.8
1986	\$12.5	\$ 7.4	\$19.9	\$ 8.9
1987	\$19.0	\$ 8.5	\$27.5	\$ 8.3
1988	\$21.8	\$28.1**	\$49.9	\$11.4
1989	\$52.2	\$ 8.0	\$60.2	\$19.2
1990	\$13.5	\$47.3**	\$60.8	\$ 3.1
1991	\$42.2	\$ 5.0	\$47.2	\$10.1

\* Includes fines, restitutions, recoveries, settlements, judgments and penalties.  
\*\* Includes high single-year savings resulting from a special project.  
Source: HHS/OIG Office of Investigations.



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## Dr. Deets

(continued from page 3)

fund 50 percent of the education bill, once the budget is brought under control. "The state right now is funding less than 35 percent of the education bill. It is mandated to do better than that, but it just doesn't have the funds," he said.

He also advocates public-private partnerships to help promote economic growth, including business incentives to expand existing businesses and create new jobs. "At the state level, we need to make the workers' compensation environment such that we aren't making the state unattractive to business," Dr. Deets said. "In addition, we have to provide a readily available work force so companies don't have to spend time educating employees."

Finally, Dr. Deets said he will urge the state to take more aggressive actions to encourage consumers and businesses to "recycle, reuse and reduce."

Dr. Deets, 44, has lived in Dixon for 32 years. He and his wife, Debra, have four children. He received his B.A. degree in 1970 from DePauw University in Greencastle, Ind., and his M.D. degree from the Loyola University Stritch School of Medicine in 1972. He completed his residency at Chicago's St. Joseph's Hospital in 1977, when he returned to Dixon to establish his practice.

He is a member of the American Medical Association, the Illinois State Medical Society and was president of the Lee County Medical Society from 1987-1989. Dr. Deets is a fellow of the American College of Surgeons, a member of the Ameri-

can College of Physician Executives, a diplomat of the National Board of Medical Examiners and a diplomat of the American Board of Surgery.

Dr. Deets is medical director and president of the Board of Directors of the Medical Arts Clinic in Dixon. From 1987-1988, he was medical director of the NOVA Health Care Plan and president of the medical staff at the Katherine Shaw Bethea Hospital from 1982-1984. Dr. Deets is also a past president of the Lee County Board of Health.

Also active in the community, Dr. Deets currently serves on the Dixon Industrial Development Commission, and was president of the Dixon Chamber of Commerce from 1981-1983. From 1983-1990, he was a director of the First Bank Dixon.

While Dr. Deets said he has always been politically active, two things

convinced him to run for state representative. "The opportunity to run was there because Myron Olson was retiring, and I decided that, at my age, this was the time I could do that," said Dr. Deets. "Secondly, I hope that I can make an impact [in the health care debate] because of the unique perspective I have as a physician."

Dr. Deets said leaving his practice behind during legislative sessions was a minimal concern. As one of a 25-member group, "I'm not leaving anyone high and dry if they need to have surgery," he said.

Since legislative sessions meet Tuesdays through Thursdays, he said he plans to schedule surgeries on other days. Nevertheless, he anticipates his legislative duties will cause a reduction in his practice during the legislative session. ▲

## AXID<sup>®</sup> nizatidine capsules

Brief Summary. Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.

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1. Data on file, Lilly Research Laboratories.

See accompanying page for prescribing information.

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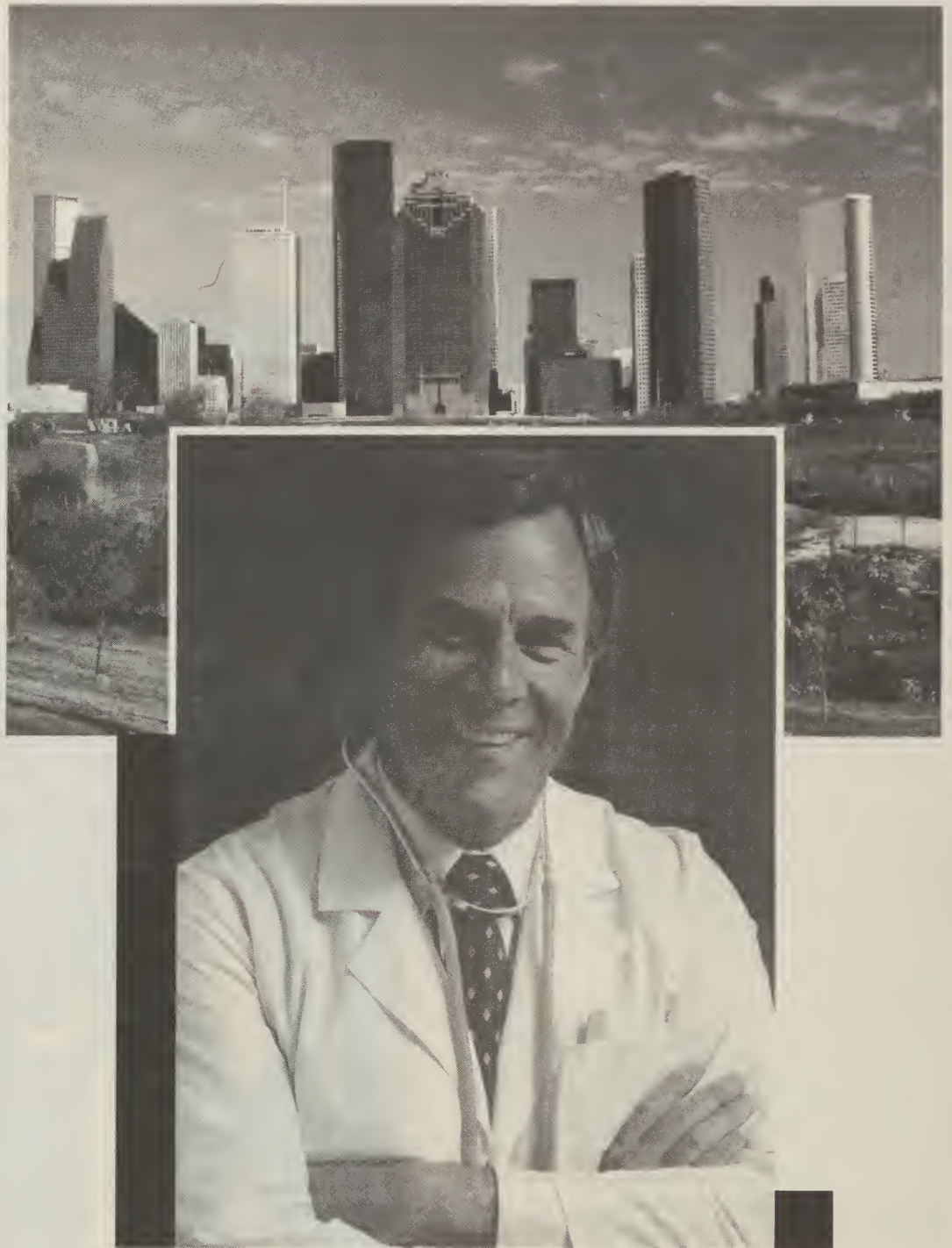
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## CLIA

(continued from page 1)

But despite the complete government rewrite of the regulations, the impending implementation of CLIA on Sept. 1 will still have wide-ranging regulatory impact.

"Our goal as physicians is to ensure quality care for our patients. Affordable and accessible lab tests are an integral aspect of providing good care," said Illinois State Medical Society President Robert M. Reardon, M.D. "We are in the process of analyzing the merits of both the new federal regulations and the current Illinois law governing physician office labs."

Critics of the rules contend the additional costs doctors would incur to continue offering lab tests in their offices and comply with the CLIA regs may force many physicians to abandon providing laboratory services. Patients would have to be referred to independent laboratories — which tend to be more expensive — to receive necessary tests. Government estimates assign an added cost from the rules of 25 cents per test.

"Because of its scope, this regulation will require the cooperation and patience of all involved. But it will deliver to millions of Americans safer, more accurate laboratory testing," said Gail Wilensky, Ph.D., who heads the Health Care Financing Administration. HCFA is the HHS agency responsible for CLIA oversight.

*"Our goal as physicians is to ensure quality care for our patients. Affordable and accessible lab tests are an integral aspect of providing good care."*

The first word physicians will hear from the government about the new rules will come in May, when HCFA mails an application form to physician office laboratories. This survey, intended to supplement the information HCFA obtained in the November 1991 CLIA survey, will be accompanied by a bill for a "registration certificate." Certificates enable the physician office lab to continue operating until a formal inspection is conducted. Registration certificates are valid for two years and cost between \$100 and \$600; fees are determined by the volume and complexity of tests performed.

The physician charges called for under CLIA are user fees to cover the cost of the regulation program. When Congress passed the laboratory improvement law in 1988, it did so with the intent that the program be self-supporting.

After an inspection is scheduled, the lab will be classified as waived, moderately complex or highly complex. A new operational certificate will be issued, with costs ranging

from \$300 for waived and low-volume moderated classified labs to \$3,000 for high-volume, high-complexity labs.

Waivered class labs are exempt from the biennial HCFA inspections, the rules state, but could be subject to surprise inspections resulting from complaints. Other classified labs must pay for the biennial inspections — which will vary from state to state.

### **Eight tests in waived class**

In the draft, only five tests were waived, and most physicians had hoped the government would expand significantly the list of tests an office lab could perform and still receive a waived classification. The government, however, chose only

eight simple tests to include as waived tests. They are: dipstick/tablet urinalysis, ovulation tests, urine pregnancy tests, non-automated erythrocyte sedimentation rate, hemoglobin (copper sulfate), fecal occult blood, spun micro-hematocrit, and blood glucose testing only with monitoring devices approved by the U.S. Food and Drug Administration for home use.

A bright spot in the new regs are the somewhat generous deadlines the government has proposed for physician compliance with proficiency testing programs and implementation of sanctions for rule violations, Dr. Reardon said. All labs regulated by CLIA will have until Jan. 1, 1994, to enroll in a proficiency testing program. The government will hold off

sanctioning physicians who do not do well in proficiency checks of their lab results until 1995, although doctors will be required to correct the deficiencies.

"We are concerned that the costs the government proposes for physicians to register and maintain their labs are significant," Dr. Reardon said. "But physicians always have been committed to providing top-notch laboratory tests to their patients. These rules won't change that, but they do add to the overall cost of health care." ▲

*Watch upcoming issues of Illinois Medicine for more in-depth coverage of the CLIA regulations.*

## **Concerned about CLIA'88?**

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# Match Day

(continued from page 1)

can make the competition tough for students hoping to join them. But some Illinois students feel confident of the impressions they have made at their selected programs.

Richard Guttman, a fourth-year medical student at the University of Illinois at Chicago, felt his interviews were more "benign" than he had expected.

"I expected to be interrogated," he says, "but it was mostly sitting and talking. I was pleasantly surprised."

Guttman expects to match with a surgery residency program in the Chicago area. He applied to 22 programs, received 20 interview offers, and went to nine interviews. He says he was most nervous about writing his personal statement in his applications.

"I wrote a four-page draft, and had a hard time cutting it down," he says. "There is a fine line between making a good impression and seeming cornball."

Guttman was raised in the Chicago area and says that while he really loves Chicago, he doesn't feel there are a lot of programs available. He had applied to programs in the Midwest and the East, but says he is now more focused on Chicago.

"My wife is expecting a baby in the fall, so I have family considerations," he says. "I wish I would have applied to more Chicago programs."

Guttman has ranked the University

*"I expected to be interrogated, but [the interview] was mostly sitting and talking. I was pleasantly surprised."*

— Richard Guttman,  
University of Illinois



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ing working hours, patient population, information about the attendings and the amount of supervision.

"I was concerned about who came to the program, what schools they came from and what specialties they were going into," Buergler says. "I tried to find programs that were suited to my own interests."

Like Guttman, Buergler found the interviewing process to be less stressful than he had imagined.

"My interviews were very laid back," he says. "The programs seemed to be more interested in recruitment rather than selection. They spent a lot of time addressing the good points of the programs."

"I think that being less concerned about it might have helped," he adds. "But you never know until you go through it."

Buergler is a Chicago native who applied to programs around the

In all, Buergler ranked 14 programs and feels "very confident about matching. There's not a single place I ranked that I wouldn't feel happy going to," he says.

## **Some interviews more personal than others**

Anu Natarajan, a match candidate from the Southern Illinois University School of Medicine, found that some of the programs where she interviewed were much more personal than others.

"Some were like large open houses," she says. Ironically, her first choice came from one of the larger interviews.

Natarajan, who is from Olney, applied to and ranked only programs in Los Angeles. Her first and second choices are both UCLA programs — a primary care and traditional track. She says she has wanted to go to Los Angeles, where her fiancé lives, and did two rotations there to see if she would like it.

"I enjoyed it," she says. "I found that they are much more aggressive in treatment, because there are more infectious diseases."

Natarajan is seeking a pediatric position, and her ultimate interest is Third World medicine.

"The interviewing process was very tiring, but it was fun," she says. "I did nine interviews in 10 days, and they all started to meld together. I began to get confused between programs."

Both Natarajan and Buergler attended an Illinois State Medical Society Medical Student Section program on preparing for residency interviews last October. Natarajan said it was interesting and she learned what residency program directors were looking for. She also learned a lot from the interview process itself, she says. Of the nine programs she applied to, Natarajan ranked five.

"Lifestyle is important to me," she says. "I wanted to find a program

*"Lifestyle is important to me. I wanted to find a program where life is a little easier. I'm also interested in chronic and exotic patients."*

— Anu Natarajan, Southern  
Illinois University



Ron Ackerman

of Illinois residency program first, because he knows the program well and understands its "lumps and bumps." His second and third choices are programs at Case Western Reserve University in Cleveland and the Medical College of Wisconsin.

"I was very impressed with these programs, but a one-day interview isn't enough," he says. "I don't want to risk the rest of my life on one day. But I'd be very happy to match with any of my choices."

"It's funny, my interviews went really well," Guttman continues. "Now I've cast my die, and I haven't developed an ulcer yet."

## **Opportunity to talk with residents**

A part of interviewing that John Buergler found most helpful was speaking with residents. Buergler, a match candidate at the University of Chicago, says he tried to establish whether residents were happy in their programs, as well as determin-

country. His first three choices, however, are all in Chicago.

"The University of Chicago is my first choice because the teaching is outstanding, as well as the quality of education and commitment to you as an individual," he says. "I may not have been able to realize their commitment to teaching if I hadn't been here [as a student]."

Buergler, whose second and third choices are the Northwestern University program and Rush, plans to join an internal medicine program, which he considers to be less competitive than other specialties. And while Buergler says he had no particularly bad experiences during his interviewing process, he does wish it had been less expensive.

"It was not much of a vacation," he says. "I spent a lot of money on hotels and airfare. A few programs reimbursed me for hotel expenses, and I stayed with friends when I could."

*"My interviews were very laid back. The programs seemed to be more interested in recruitment rather than selection. They spent a lot of time addressing the good points of the programs."*

— John Buergler, University of Chicago

## Family practice match prospects still looking bleak

by Anna Brown

EVEN THOUGH Illinois filled 2 percent more of its residency slots in 1991 than in the previous year, some family practice programs are still suffering from a lack of candidates.

"This year is really dismal," says David Garretson, D.O., a faculty member at the Belleville Family Practice Residency Program. "This year we had 15 applications for six slots, which is very, very meager."

Despite not always filling first-year residency positions during the match, Dr. Garretson says the Belleville program is very successful at attracting residents to second-year slots. Nevertheless, Dr. Garretson says this is the worst year the program has ever had.

Fred Z. White, M.D., family practice residency program director at the University of Illinois College of Medicine at Peoria, says that his program tries to conquer the shortage of family practice candidates by attracting international medical graduates. He expects to fill five of eight slots during the match, filling the remaining three with IMGs.

A problem he found is that IMGs sometimes have spent a long time out of school, and it is difficult to ascertain what they have been doing.

"It is also very hard to compare academic backgrounds," Dr. White explains, especially when they come from Eastern bloc countries. Still, Dr. White says his program does not judge candidates by where they come from, but rather by who they are and what they want. "That's why the interview is most important," he says.

This year, Dr. White has interviewed one Lithuanian medical student, two Italians and several Filipinos. One U.S. citizen who graduated from a foreign medical school has already signed on, he says. ▲

where life is a little easier. I'm also interested in chronic and exotic patients."

Although she's not nervous about matching, Natarajan says if she doesn't match she'll take a year off.

"It was my intention to go out there in the first place," she says. "If I didn't match, I would try again next year and sit out to do research." ▲



M. Candee Studios



## Snapshot

Illinois Medicine asked physicians at the Illinois State Medical Society's 1991 Residency Program Directors Seminar: Former Surgeon General C. Everett Koop, M.D., has been quoted as saying, "Medical education must produce physicians in the future who are as concerned about caring as they are about curing." How should your residency program respond to that challenge?



**Norbert Nadler, M.D.**  
Transitional Residency Program  
Director, Ravenswood Medical  
Center, Chicago

"We are teaching the residents to be physicians. Unfortunately, we're not teaching enough of the residents to be human beings. I think there are some deficiencies in the programs. [They] should emphasize that a patient does need [a physician to be] a human being as much as he needs a physician."



**Edwin E. Nebblett, M.D.**  
Family Practice Residency  
Program Director,  
Hinsdale Hospital

"I could not agree more. The problem that we have is that taking the high road and being a physician because we want to [make] a contribution is, to me, more important than being in the profession because we want to get something out of it. We look for the people who hold that same standard."



**G.E. Boyd, M.D.**  
Residency Program Director  
University of Illinois at Rockford

"I think we're already responding. But I think we all need to do that. And I see other of the subspecialties beginning to pick up our line that we have to look at the total person. Actually, we should be doing the patient's agenda – not our agenda – in their care. So we need to find out what they want from us and then meet that need. It's a marketing situation like any other business."



**Ruth Seeler, M.D.**  
Associate Residency Program  
Director, University of Illinois  
Medical Center, Chicago

"I think people who are going into primary care are caring physicians because they are not attracted to the fact that if you go into the surgical fields you can make five, six, seven times what a poor little pediatrician is going to make." ▲

Interviews by Janice Rosenberg  
Photos by M. Candee Studios

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## Obituaries

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

### \*Adams

Ernest F. Adams, M.D., of Peoria, died November 26, 1991 at the age of 73. Dr. Adams was a 1947 graduate of the Oregon Health Science University Medical School, Portland, Ore.

### \*\*Akre

Osmund H. Akre, M.D., of Duluth, Minn. (formerly of Chicago), died December 19, 1991. Dr. Akre was a 1940 graduate of Rush Medical College, Chicago.

### \*\*Baumrucker

George O. Baumrucker, M.D., of Sun City, Ariz. (formerly of Berwyn), died November 16, 1991 at the age of 86. Dr. Baumrucker was a 1932 graduate of Rush Medical College, Chicago.

### \*Canterbury

John R. Canterbury, M.D., of Peoria, died October 31, 1991 at the age of 74. Dr. Canterbury was a 1943 graduate of Northwestern University Medical School, Chicago.

### \*\*Carto

James Carto, M.D., of Northbrook, died September 27, 1991 at the age of 78. Dr. Carto was a 1938 graduate of Chicago Medical School.

### \*\*Collins

Thomas J. Collins, M.D., of Palos Heights, died December 6, 1991 at the age of 76. Dr. Collins was a 1941 graduate of Northwestern University Medical School, Chicago.

### \*\*Crilly

James A. Crilly, M.D., of Edwardsville, died November 17, 1991 at the age of 80. Dr. Crilly was a 1937 graduate of Georgetown University School of Medicine, Washington, D.C.

### \*\*Crout

George T. Crout, M.D., of Flanagan, died November 20, 1991 at the age of 87. Dr. Crout was a 1932 graduate of Case Western Reserve University

School of Medicine, Cleveland.

### \*\*Fischer

Otto H. Fischer, M.D., of Earlville, died December 23, 1991 at the age of 89. Dr. Fischer was a 1933 graduate of Loyola University Stritch School of Medicine, Maywood.

### \*Garrison

Paul P. Garrison, M.D., of Winchester, died October 15, 1991 at the age of 84. Dr. Garrison was a 1942 graduate of Chicago Medical School.

### \*Hite

William K. Hite, M.D., of Charleston, died June 29, 1991 at the age of 74. Dr. Hite was a 1942 graduate of Vanderbilt University School of Medicine, Nashville, Tenn.

### \*\*Kweder

David J. Kweder, M.D., of Waukegan, died October 29, 1991 at the age of 85. Dr. Kweder was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

### \*Lopez

Fernando A. Lopez, M.D., of Oak Brook, died October 2, 1991 at the age of 56. Dr. Lopez was a 1962 graduate of Facultad de Medicina de la Universidad de Madrid, Madrid, Spain.

### \*\*Marcus

Samuel M. Marcus, M.D., of Skokie, died November 14, 1991 at the age of 79. Dr. Marcus was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

### \*Mizock

Sidney L. Mizock, M.D., of San Diego, Calif. (formerly of River Forest), died December 7, 1991 at the age of 82. Dr. Mizock was a 1936 graduate of Chicago Medical School.

### \*\*Murphy

Francis C. Murphy, M.D., of Park Ridge, died November 22, 1991 at the age of 78. Dr. Murphy was a 1941 graduate of Loyola University Stritch School of Medicine, Maywood.

### \*\*Needles

Joseph H. Needles, M.D., of New Athens, died October 31, 1990 at the age of 79. Dr. Needles was a 1935 graduate of Washington University School of Medicine, St. Louis.

### \*Rosenzweig

Oscar J. Rosenzweig, M.D., of Chicago, died September 27, 1991 at the age of 70. Dr. Rosenzweig was a 1944 graduate of Orvosi Fakultás Szegedi Orvostudományi Egyetem, Szeged, Hungary.

### \*\*Sherrick

Joseph C. Sherrick, M.D., of Northbrook, died October 11, 1991 at the age of 74. Dr. Sherrick was a 1941 graduate of Harvard Medical School, Boston.

### \*\*Sorce

John P. Sorce, M.D., of Mt. Prospect, died October 23, 1991 at the age of 80. Dr. Sorce was a 1934 graduate of Facoltà di Medicina e Chirurgia dell'Università di Palermo, Palermo, Italy. ▲

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# FROM THE ILLINOIS NEWS DEPARTMENT OF PROFESSIONAL REGULATION

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SEPTEMBER 1991

Caldwell J. Gaffney, St. Louis, Missouri – physician and surgeon license placed on probation until May 24, 1993 after his license to practice was disciplined by the state of Missouri.

Fernando Jimenez, Margate, Florida – physician and surgeon license suspended indefinitely after his Florida license was disciplined as a result of allegations of gross malpractice, filing false reports and failure to keep written medical records.

Kanwaljit S. Serai, Eastpoint, Florida – physician and surgeon license placed on probation for two years after his Florida license was disciplined for allegedly misdiagnosing certain complaints of patients. In addition, he submitted a false bill to an insurance company and charged an excessive amount for services.

Eugene Michael Molnar, Newport Beach, California – physician and surgeon license suspended indefinitely after his license to practice was disciplined by the state of California.

## High court ruling

(continued from page 1)

said.

"You can extrapolate from that the high number of frivolous suits that were clogging Illinois courts," he said. "Since then, we've seen a dramatic reduction in the number of suits filed according to court records. And this acts to the advantage of the patients who have really been injured, allowing them access to the courts and quicker redress of their injuries."

The law allows plaintiffs to select a physician of their choice to attest that the injury being alleged in a malpractice suit resulted from negligent care. When selecting a physician to provide a certificate of merit, however, plaintiffs must choose a physician who practices in the same specialty as the defendant physician. An affidavit supporting the plaintiffs' claim must then be filed with the court.

### Law does not add new burden

Specifically, the *DeLuna* decision reverses an earlier appellate ruling and upholds the constitutionality of requiring a plaintiff to obtain a certificate of merit. The *McAlister* decision affirmed an appellate court ruling dismissing a medical malpractice lawsuit on the grounds that the plaintiff did not provide a merit certificate to the court.

"The Supreme Court found that the statute was rationally related to

the legislative purpose of limiting frivolous malpractice cases," said Saul J. Morse, ISMS legal counsel. "It also found that the role of the physician [in attesting the injury resulted from negligent care] was merely to do, at an earlier stage, that which he or she would have to do subsequently; that being to offer expert opinion as to whether the standard of care

*"We've seen a dramatic reduction in the number of suits filed, according to court records. And this acts to the advantage of the patients who have really been injured, allowing them access to the courts and quicker redress of their injuries."*

had been deviated."

Morse explained that the court viewed the certificate requirement as analogous to court-imposed requirements that attorneys "accurately and adequately" investigate malpractice cases before filing them and the process of lining up expert testimony. The court, therefore, found the law

does not pose new burdens on plaintiffs, he added.

"In all instances, [the court] upheld the statute," Morse said. "The importance of this, I believe, is that it should have the effect of limiting future appeals on this point, as it tends to close the door on virtually every theory of constitutional attack that has been levied against this statute in the almost seven years since it became law. Hopefully, this will put an end to attacks on this statute based on principles of constitutional law. I view that as a very positive step."

Despite the optimism in the medical community surrounding these advantageous decisions, more work still remains in the tort reform battle, Dr. Reardon said. The medical society – bolstered by support from Gov. Jim Edgar and President Bush – is renewing its call to establish caps on non-economic damage awards. Dr. Reardon said skyrocketing judgments for non-quantifiable, non-economic losses such as pain and suffering are forcing health care costs upward because physicians are practicing defensive medicine and insurance companies are hiking premiums.

"We're encouraged by the Illinois Supreme Court's support of the certificate of merit provisions," Dr. Reardon said. "Now we can confidently go forward with the next stage of the fight – ridding the court and health care systems of overblown jury awards for non-economic losses." ▲

## Classified Advertising

Send all advertising orders, correspondence and payments to *Illinois Medicine*, Twenty North Michigan Ave., Suite 700, Chicago, IL 60602. Telephone: 312/782/1654; 1/800/782/ISMS. *Illinois Medicine* will be published every other Tuesday. Ad copy with payment must be received at least four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

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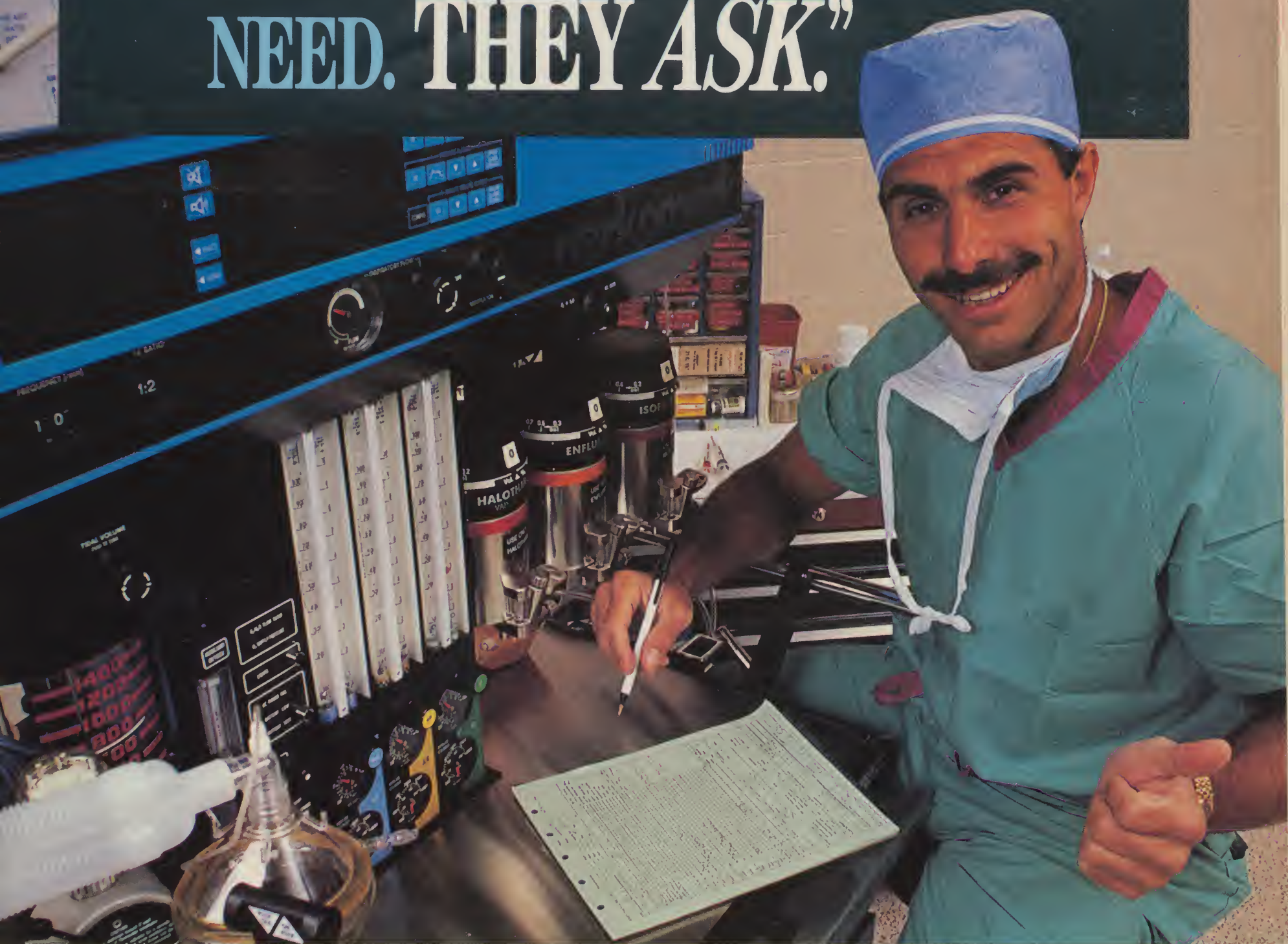
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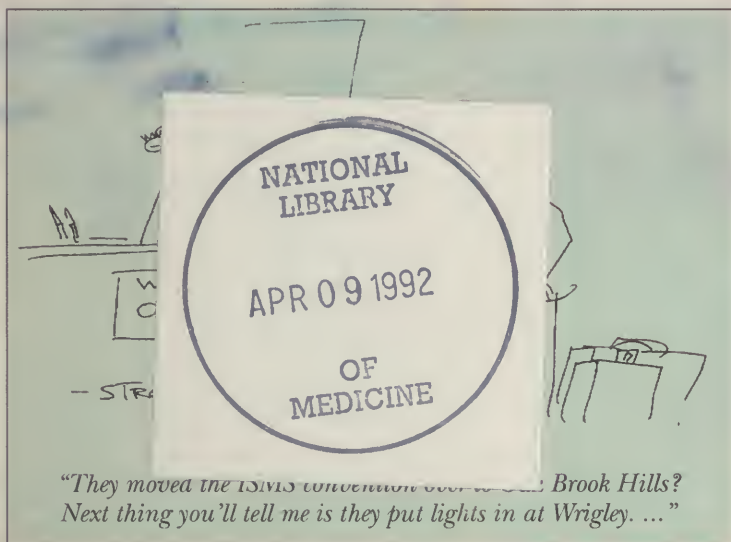


# Illinois Medicine

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March 27, 1992

ILLINOIS STATE MEDICAL SOCIETY



## TB increase causes concern

by Tamara Strom

THE RATE OF tuberculosis infections in some Chicago neighborhoods rivals that of Third World nations, according to Chicago Department of Health officials. Concern surrounding this dramatic increase is prompting city health officials to launch a full-scale intervention campaign to identify those at risk and those infected and to provide them

with preventive therapies.

"As providers of care, we have to be aware of what is happening in these communities," said John Kuharik, director of CDOH's tuberculosis program, during a recent presentation to area health care workers. "This is a real problem. We cannot continue to treat TB as we have for the past 20 years. The sanitariums were closed years ago. New dramatic outreach programs are needed."

Overall, Chicago's TB incidence increased 7 percent in 1991, to 755 cases from 705 cases in 1990. This is a 16 percent jump from the 649 cases reported in 1987, the year Chicago began experiencing a rise in TB after years of decline.

Two Chicago neighborhoods — East Garfield and Uptown — have the most troubling statistics, according to CDOH, with infection

(continued on page 10)

## 1992 House of Delegates annual meeting

### The location changes, but the process stays the same

by Kevin O'Brien

AS THE CARTOON above illustrates, nothing is forever.

This year the Illinois State Medical Society House of Delegates pulls up stakes in northwest suburban Rosemont, where it has held its annual meeting for six years, and heads for the western suburb of Oak Brook. Though the location is different, the time-honored process of determining ISMS policy through resolution, debate and consensus will continue.

From Friday, April 10, through Sunday, April 12,

ISMS trustees, delegates and alternate delegates from throughout the state will convene at the Oak Brook Hills Hotel to debate 85 resolutions. Though not a record number of resolutions, ISMS officials said, it is a heavier load than in recent years.

Consideration of the resolutions in five reference committees is scheduled to begin at 2 p.m. Friday. As in past years, any ISMS member — delegate or not — may attend and testify at the reference committees.

All day Saturday and Sunday morning, delegates will



consider altering the terms of ISMS officers and trustees; health care system reform, including public information campaigns about the various proposals; peer review and utilization review; hospital medical staff

autonomy; helmets for motorcyclists; family violence; anti-tobacco measures; regulation of tattoo parlors and electrolysis; and a host of others. *Illinois Medicine* will examine several selected resolutions in its next issue.

On Saturday morning, Robert M. Reardon, M.D., of

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G.W.N. Eggers, M.D., (left) president of the American Society of Anesthesiologists, visits with Henri S. Hovdala, M.D., at the Illinois Society of Anesthesiology's March 6 gala at Chicago's Museum of Science and Industry. ▲

Wm. Daniels/The Photo Partners

## Physicians face added fees, oversight from new lab rules

by Tamara Strom

NOW IS THE TIME for physicians to determine what impact the new federal clinical laboratory (CLIA) rules will have on the services they offer their patients and act accordingly. With the prospect of added regulatory fees and increased government oversight, physicians should consider carefully the number and volume of tests they perform in their office labs.

The Illinois State Medical Society and the Illinois Department of Public Health are both currently analyzing

the relationship between the new CLIA rules and existing state clinical laboratory regulation. ISMS will continuously keep physicians abreast of any additional regulatory changes.

Although the federal rules to implement the Clinical Laboratory Improvement Amendments of 1988 are less stringent than the draft rules proposed two years ago, they pose several compliance deadlines for physicians, deadlines that are just around the corner. Implementation of the entire standard will be accomplished

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## The changing face of medicine

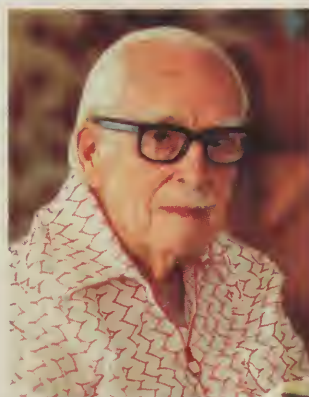
### Through the eyes of ISMS' oldest past president

by Rachel Brown

THE OLD ADAGE says, "The more things change, the more they stay the same." Leo P.A. Sweeney, M.D., who at 92 is the Illinois State Medical Society's oldest past president, is proof of that.

Although costs of medical procedures have changed drastically since Dr. Sweeney embarked on his 1952-53 ISMS Presi-

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Leo P.A. Sweeney, M.D., at his Ft. Lauderdale home.

Al Sides

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## Illinois measles down 98 percent in 1991

Only 27 cases of measles were reported in Illinois last year, a 98 percent decrease from the 1,152 cases reported in 1990, the second year of Illinois' last major measles outbreak, according to the Illinois Department of Public Health.

IDPH Director John R. Lumpkin, M.D., attributes the drastic decline in reported measles cases to new state requirements for a second dose of measles vaccine and more funding for immunizations.

"The decrease in measles cases dramatically underscores how preventive measures can greatly reduce the incidence of disease and protect our population, particularly children, from illness and possible complications," Dr. Lumpkin said. "For every dollar spent on immunizations, we can save \$10 in treatment expenses."

For the past three years, the General Assembly has appropriated about \$11 million for IDPH to buy 700,000 doses of the vaccine. Most vaccines were administered at public clinics as second doses for school-aged children. IDPH has required proof of a second dose since 1990 for children entering the fifth grade and college. Last year, the department expanded the mandate to include ninth grade students, and for the 1993 school year, all elementary and secondary school students will be required to show proof of two immunizations.

## Physicians providing charity health care

Nearly two-thirds of the nation's physicians provided 6.5 hours of free or discounted medical care to needy patients during their last completed week of practice, according to an American Medical Association tele-

phone survey. Annualized at about 300 hours, this outpaces many of the suggestions about the amount of charity care doctors should provide, the AMA said; 50 hours a year is an oft-quoted baseline.

On average, doctors surveyed provided three hours of free care and 3.6 hours of reduced-fee care per week. Deeply discounted Medicare or Medicaid services were not included.

Among the specialties surveyed, general practitioners/family physicians (71.2 percent) and surgeons (70.2 percent) were most likely to provide charity care compared with pediatricians (53.9 percent) and pathologists (52.2 percent). Obstetricians/gynecologists (61.7 percent) and internists (62.2 percent) ranked about midpoint in the survey.

While a greater number of physicians in primary care specialties reported providing about 5.5 hours of charity care a week, surgeons reported 7.7 hours a week, radiologists 9.2 hours and anesthesiologists 11.4 hours.

Overall, 72.6 percent of physicians practicing in rural areas reported delivering charity services, compared with 63 percent of physicians in small metropolitan areas and 61.1 percent of doctors in large urban areas. Rural physicians deliver about 2.5 hours of free care and 3.1 hours of reduced-fee care, while urban physicians deliver about three hours of free care and 3.5 hours of reduced-fee care in small cities and approximately 3.2 hours of free care and 3.8 hours of reduced-fee care in larger cities.

In the East North Central region, which includes Illinois, the survey showed 67.3 percent of physicians surveyed provided charity care. Physicians in the area reported giving 2.3 hours of free care and 3.2 hours of reduced-fee care a week. ▲

— by Tamara Strom



At the Midwest Clinical Conference Feb. 29 in Chicago, Robert C. Muehrcke, M.D., (left) of Oak Brook, receives the Chicago Medical Society's Public Service Award from CMS President M. LeRoy Sprang, M.D. Right: U.S. Rep. Dan Rostenkowski (D-Chicago) addresses physicians at the conference. ▲

## Illinois physicians face slowdown in state reimbursements

by Kathy Meyer

CONTINUING a pattern that shows little sign of abating soon, Illinois physicians who care for state employees have not yet received payment for services rendered last November.

The Illinois Department of Central Management Services, which administers the state employee health insurance fund, is taking up to 90 days to pay physician bills once they are received. That delay is expected to stretch to 150 days before the fiscal year ends June 30.

"The governor is very concerned about the delay in paying medical bills for state employees. It's a situation the governor is determined to address and to address forthrightly," said Mike Lawrence, the governor's press secretary. "There are two options that have been proposed publicly. One is that we borrow [money] without any plan to pay it back. Two is that we raise taxes. Those options have been unacceptable to the governor."

"If they did it [didn't pay] to teachers, they wouldn't teach. If they did it to garbage collectors, they wouldn't work. They do it to doctors, but doctors feel a responsibility, so we continue to work," said Craig Backs, M.D., a Springfield internist who belongs to a 17-physician group practice.

"The Illinois State Medical Society continues to work with the state to find a long-term solution to the budget problems encountered by the state employee health insurance fund," said ISMS President Robert M. Reardon, M.D. "We want to see the matter resolved for the health of state workers, as well as for the sake of Illinois physicians."

For the past three years, DCMS reimbursements to physicians have been slowing down as money in the insurance fund ran out near the end of each fiscal year. This year the slowdown has come earlier, reflect-

ing the state's budget crunch.

"We started this year with a shortfall," said Helen Adorjan of DCMS. "The hole just keeps getting deeper and deeper." The agency, which insures 300,000 state employees, retirees and their dependents, ended last year with a \$66.3 million shortfall. That had to be covered by this year's appropriations of \$441.9 million, leaving \$375.6 million to cover the projected \$525 million in expenditures for fiscal 1992. As of March 9, \$57.9 million in medical claims remained unpaid because money was not available to cover them.

"That makes it extremely difficult, if not impossible, to make ends meet," said Kurt Flaherty, business manager at Capitol Healthcare, a private clinic in Springfield. State employees account for 20 percent of the dollar volume of privately insured patients treated at the six-member practice. "We have bills that continue to come in and must be paid. If the money's not coming in, we have to pay bills late, incurring interest charges," Flaherty said.

"I anticipate we're going to have to take out a loan to meet our payroll," said Dr. Backs. State employees account for 15 percent to 20 percent of the practice's gross income. "Salaries are budgeted so that we don't keep a lot of reserves. Salaries must be delayed if we fall [short of] cash flow. For some, that's OK. For others, it's not."

To help ease the situation, some physicians are starting to ask DCMS patients directly for payment, even if it is only a token amount. At Capitol Healthcare, "We're asking them to pay whatever they can afford (toward their bill) — even \$5 or \$10 — just so we can get over the hump," Flaherty said.

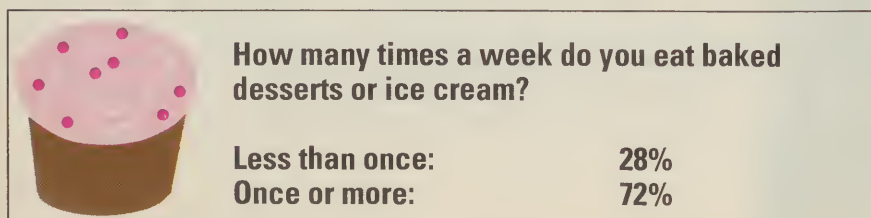
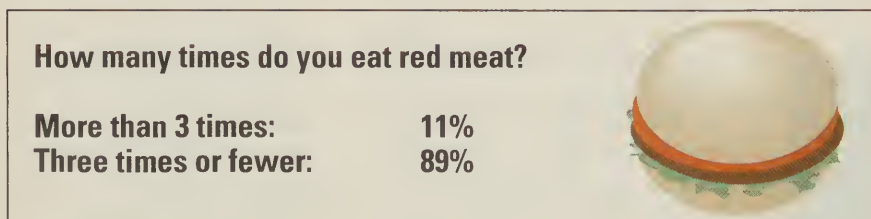
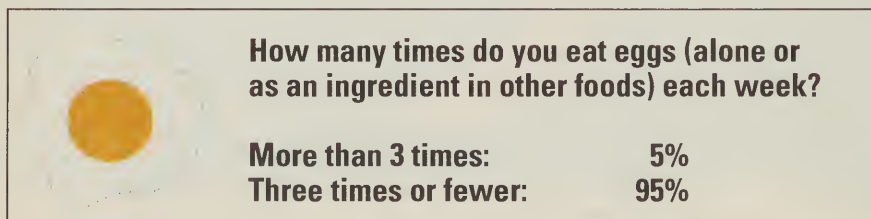
Dr. Backs' practice plans to set up a loan program through a local bank for those who cannot pay their bills. Still other physicians are asking for

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## Physician Facts

### Physicians' health regimens

Doctors were asked about their health habits in 1991. These are results of some questions about their diet:



Source: Harvard Health Letter

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# Clearing up myths about the IDPA review system

by Tamara Strom

**HORROR STORIES ABOUT** the system used by the Illinois Department of Public Aid to audit and review Medicaid-participating physicians dot the medical community's grapevine. But only a small number of Illinois physicians are actually reviewed by the department and, of those, only a fraction are terminated from the program.

"Public Aid and the [Illinois State Medical Society] work closely to make the process fair and workable," said Paul Keller, bureau chief of the IDPA Bureau of Medical Quality Assurance. "If someone is providing inadequate care, that is addressed. Our first responsibility is that Medicaid recipients receive quality care. But we're not looking to put anyone out of business or out of the program. Quite the contrary, we want to keep physicians participating."

Because a healthy portion of Medicaid is funded by federal monies, Keller explained that IDPA is under federal mandate to review and analyze "a certain number" of providers. The percentage of providers actually reviewed is small — about .005 percent, he said. So although 24,563 Illinois physicians submitted Medicaid claims last year, only about 600 doctors were reviewed by IDPA's Narrative Review Committee.

The NRC looks at physician claims that a computer scan determines fall out of the norm. The computer search identifies potential excessive and underutilization of services.

The committee then makes recommendations about whether any of the physicians should be referred for peer review because of quality-of-care issues, Keller said. He stressed, however, that in the majority of cases no further action is taken by the department. Of the approximately 600 cases screened by the NRC last year, nearly 400 were closed with no further action, while another 200 were referred for peer review.

The cases referred for peer review are examined by the department's Medical Quality Review Committee, made up largely of physician consultants nominated by ISMS. The Society seeks nominees from county medical societies, who submit names that are then forwarded to IDPA.

"Quality assurance is only performed by physicians' peers on the committee," Keller said. "They make the decision for their peers."

If a physician is referred for peer review, the MQRC panel requests a small sample of patient records. Last year, about 55 Illinois physicians were called in to meet with the panel to explain potential discrepancies in patient charts. Of those, only 23 were recommended for one-year terminations from the Medicaid program because of quality-of-care issues identified by the MQRC. Physicians may appeal adverse committee recommendations through a fair hearing process. After a year out of the program, these doctors may then apply to be reinstated. In 1991, six physicians who were terminated in 1990 were reinstated.

Physician reviewers for the program report that quality-of-care issues generally fall under six broad categories:

## News Analysis

- Failure to appropriately diagnose, treat and manage hypertension.
- Failure to appropriately diagnose, treat and manage diabetes.
- Failure to take a proper medical history.
- Deficiencies in clinical notes and record keeping.
- Poly-drug concerns relating to possible prescribing of contraindicated drugs, dangerous drug combinations or excessive prescribing of certain classes of drugs without proper testing, such as antibiotics.
- Psychosocial problems such as properly treating addicted patients.

An additional area the committee is concerned about is prenatal care. Physicians must be sure not to bill for prenatal care without proper

documentation of appropriate management and testing.

A growing component of the IDPA review program is referring physicians for continuing medical education. The Chicago Medical Society has established CME programs that correspond with the most frequent areas of quality deficiencies found through the peer review process.

CMS hosted the first such program last October. Physician reviewers, department staff and attendees indicated this approach was successful. ISMS has traditionally urged the department to pursue educational alternatives instead of terminations and suspensions, when appropriate.

IDPA also has the authority to audit physicians' records to identify

billing aberrancies. Although ISMS supports quality-of-care focused reviews, the Society opposes heavy-handed fiscal audits in which IDPA seeks to recoup what it determines is overpayment or reimbursement for services not rendered. IDPA, however, stresses that the main goal of its program integrity process is assuring quality care for its recipients and only undertakes financial audits in extreme circumstances. Last year, 31 such audits were performed.

"The review system is pretty straightforward," Keller said. "It's a sophisticated system that compares apples and apples. It's not a kangaroo court."

Physicians who require additional information about MQRC or the hearing process may call the ISMS Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. ▲

## Blue Cross<sup>®</sup> Blue Shield<sup>®</sup> **REPORT** *FOR Illinois Physicians*

### LAW STOPS CERTAIN PHYSICIAN REFERRALS TO OWN LABS

Federal law prohibits physicians from making referrals for clinical laboratory services after December 31, 1991, to entities with which the physician, or a member of the physician's immediate family, has a financial relationship except under specific circumstances.

The law also prohibits health care entities from billing Medicare, the beneficiary, or any other party for clinical laboratory services performed after December 31, 1991, as a result of a prohibited referral.

Clinical laboratory services performed after December 31, 1991, may not be paid to entities that have not completed and returned the HCFA survey on financial relationships. The survey was sent last September. Entities that had not returned the survey have been sent warning letters with another survey.

The Medicare claim must contain the name and UPIN of the physician who ordered each clinical laboratory test or who referred specimens or the Medicare beneficiary to the entity furnishing clinical laboratory services. (If the test was performed by the referring/ordering physician, the physician must enter his or her name and UPIN as the ordering/referring physician.)

Performing entities use a "Q4" modifier on claims if the referring/ordering physician has a financial relationship with the entity but the service qualifies for an exception as an in-office laboratory service, prepaid plan service, or a pathologist consultation. These exceptions are defined below. A "Q4" modifier is not required if no financial relationship exists between the referring/ordering physician and the performing entity.

Services must meet the following three requirements to meet the "in-office laboratory" exception.

#### 1. Services are performed:

- a. personally by the referring/ordering physician;
- b. by a physician who is a member of the same group practice as the referring physician; or,
- c. by individuals who are employed by the physician or group practice and are personally supervised by the physician or another physician in the group;

and

#### 2. The tests are furnished in:

- a. the same building in which the referring/ordering physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services; or
- b. another building that is used by the group practice for centrally furnishing the group's clinical laboratory services, if the physician is a member of a group practice;

and

#### 3. The services are billed by:

- a. the physician who performed or supervised the services;
- b. the group practice of which the referring/ordering physician is a member; or,
- c. an entity that is wholly owned by the physician or the physician's group practice.

A group practice is defined as a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or a similar association. The association must meet the following requirements:

- a. Each physician who is a member of the group must provide substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, and personnel; and
- b. Substantially all of the services of the group's physicians must be furnished through the group and be billed in the name of the group. Amounts received from these billings must be treated as receipts of the group; and
- c. The practice expenses and income of the group must be distributed in accordance with methods previously determined by group members; and
- d. The group must comply with all other standards established by the Secretary in regulations.

The "prepayment plan" exception allows referrals for services that are furnished by:

- a. a health maintenance organization or a competitive medical plan in accordance with a contract with HCFA under section 1876 of the Social Security Act;
- b. a health care prepayment plan in accordance with an agreement with HCFA under section 1833(a)(1)(A); or
- c. an organization that receives payments from HCFA on a prepaid basis for enrollees under a HCFA-approved demonstration project.

The "pathologist consultation" exception is defined as:

- a. a pathologist's request for clinical laboratory tests and pathological examination services furnished by or under the supervision of the pathologist pursuant to a consultation requested by another physician.

Violators of the referral prohibition or billers repeatedly misusing the "Q4" modifier will be identified to the Office of Inspector General for prosecution and imposition of civil monetary penalties.

(3/27/92)



## Editorial

## Doctor's Day

**D**octor's Day, which will be celebrated March 30, has its origins in an event in the history of anesthesiology. On March 30, 1842, in Jefferson, Ga., Crawford W. Long, M.D., administered ether for the first time to a patient named James M. Venable. Dr. Long was just 26 years old that day, and he charged \$2, plus 25 cents for the ether.

What began in 1933 as the state of Georgia's commemoration of the first use of a new "technology" was adopted by the U.S. Congress in 1958 to honor the dedication and achievements of the entire medical profession. So each year, federal and state proclamations are issued lauding, as Gov. Jim Edgar's 1992 Doctor's Day proclamation does, "medical advances, treatments and improved quality of life for all Illinois citizens."

A lot has changed over the years – most notably, prices. But a lot has stayed the same. At least that's what 92-year-old Leo P.A. Sweeney, M.D., the oldest president of the Illinois State Medical Society, says. Speaking to *Illinois Medicine* from his home in Ft. Lauderdale, Fla., Dr. Sweeney recounted that many of the sociopolitical issues that occupied his presidency in 1952-53 still confront ISMS presidents. Similarly, as did Dr. Long, American physicians continue to introduce new technologies and new pharmaceuticals in their ongoing commitment to provide relief and comfort to their patients.

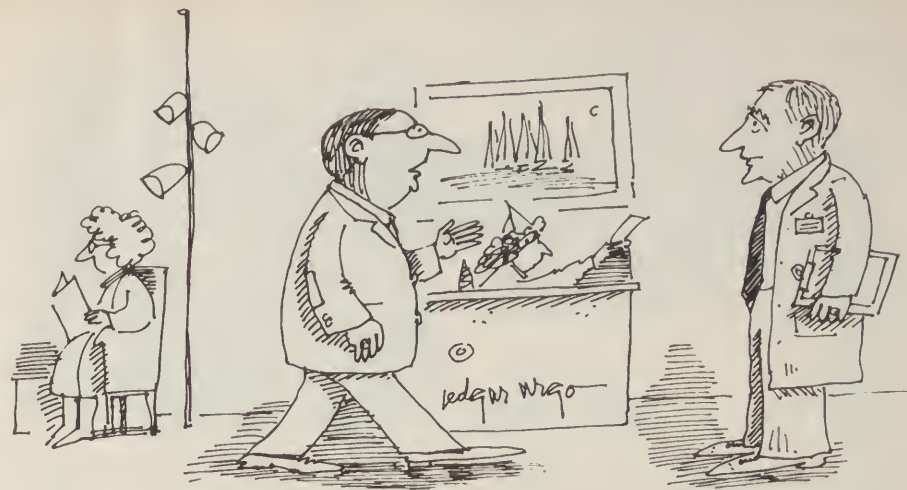
One thing, though, that Dr. Long did not need to worry about is, as Dr. Sweeney put it, the need for medicine "to resist government influences." The medical profession has no choice today. It has been thrust into the public arena, and if the profession's prerogatives are not to erode further, it must play in that arena. But there is a price for such participation. And often that price is paid in terms of the level of public discourse.

We are in the midst of an election campaign. And while the presidential campaign during the Illinois primary was reasonably civil, campaigns for other Illinois offices were decidedly not. Several races – including some that pit incumbents against each other because of redistricting – became increasingly bitter contests. Four days before the March 17 primary, one congressional candidate was injured by flying glass when someone took a shot at him as he was going home from a campaign appearance. While the incident was not specifically linked to politics, the possibility certainly exists.

Physicians as a profession also were dealt a political shot during the primary campaign. A candidate for the Democratic nomination for the U.S. Senate mailed a campaign brochure to Democratic voters that used a malpractice case to imply that the candidate, a plaintiff attorney, is a champion for health care reform. Pretending to be an illustration of the candidate's record of advocacy, the flyer was actually mean-spirited, cynically manipulative and more revealing of the candidate's priorities – and those of his media handler, a former Chicago journalist – than it was of the vitally important issue it pretended to address.

The great temptation, of course, is to respond in kind. But that is pointless, really. First, the candidate lost in the primary, so he obviously did not impress the voters. But many think that he ran this time to position himself for another race in two years. And others think he ran to advertise his lucrative practice. We are not interested in the motivation; his actions speak louder. We physicians whom he has maligned must respond by continuing to care for our patients in the best manner possible.

On March 30, 13 days after the Illinois primary, we urge all Illinois physicians to use Doctor's Day to reflect how we, as physicians, can make every attack on the medical profession, or on individual physicians, irrelevant and unfounded. ▲



"Hi Dr. Hayden ... I just read in your copy of Time that General Eisenhower has decided to run for president."

## President's Column

## The voice of the future

As the national debate on health care reform continues, it is important to understand who will be making the decisions about that reform. Two-thirds of the legislators in this country are lawyers. This means that the judicial and the legislative branches are controlled by decision makers whose training and education have taught them to focus on the past, to use history as a basis for today's decisions.

In the courtroom this makes sense. Judicial precedent, an important guideline for court decisions, turns to the past to decide today's legal questions. Similarly, in the legislature laws are often enacted reactively, in response to actions that took place in the past and are shaped by historical perspective.

None of this can or should be applied to decisions about health care. The science of medicine looks to the future and any reform of health care delivery in this country must also look to the future. This country did not become the richest, the strongest and the most successful nation in the world by looking back. Examples of America's tradition of looking ahead, of betting on tomorrow instead of clinging to yesterday, range from the settlement of the American West to the success of the American space program.

We cannot afford to let the critical decisions about tomorrow's health care be made by people who are looking back. Too often physicians are condemned as part of the health care problem. The public does not understand that physicians have no control over either spiraling hospital costs or diminishing reimbursement by state and federal agencies.

Nor can the media afford the time or space to develop in-depth analyses of the health care system. Consequently, it too often focuses on the most sensational aspects of health care in order to grab reader and viewer attention. This is why we see headlines about physician income and little coverage of physician-supplied charity care.

But the fact remains that physicians are the most educated members of the health care team, the



Robert M. Reardon, M.D.

ones most intimately involved with the delivery of health care on a one-to-one basis with patients. This unique relationship within the health care framework positions us to educate our patients, and the decision makers as well.

And make no mistake, the decisions about national health care reform should be made at the community level. It is almost a certainty that any changes will be implemented at the state level, so your input in Springfield, with your legislators in the General Assembly, will be increasingly important.

We cannot allow anyone to take away our right and responsibility to shape our profession's future. More importantly, we must accept our role as the voice of science, the voice of the future.

We must lead, and as leaders we must remind the public that while history is important, the future is critical. Our patients, the quality of their lives and the public health all depend on our acceptance of our professional responsibility and our insistence on our right to lead the health care debate.

We must assume our rightful and responsible leadership of the health care debate in our hometowns, in the state capital and in Washington, if the changes to come are to benefit our patients. We must assure that the public accepts its responsibility to decide how increased access to health care is going to be paid for, and we must exercise our right to provide the important perspective of physicians to the dialogue that will shape the future. ▲

Robert M. Reardon, M.D.  
President

## Illinois Medicine

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## Guest Editorial

National health insurance:  
Does it work abroad?

by Stephen Chapman

Like a middle-aged man in the throes of a midlife crisis, bored with his marriage and tempted by the neighbor's wife, Americans have given up on their health care system and begun itching for something new, namely those alluring national health insurance programs found in other Western countries. Like our dissatisfied husband, they see only the flaws of what they have and only the attractions of what they lack.

Anyone pointing out the likely ill effects of adopting national health insurance is met with a simple rebuttal: It works beautifully everywhere else, so why not here? The argument has been exceptionally persuasive. Most Americans know less about the Canadian health care system than they do about the Canadian Football League, but one poll found that 66 percent would trade for it sight unseen.

*"[Americans] see only the flaws of what they have and only the attractions of what they lack."*

That may be the best way to do it, since looking closely can spoil all the fun. Spoiling the fun, however, is the occasional duty of public policy organizations like the Dallas-based National Center for Policy Analysis. It has published an indispensable report, "Twenty Myths About National Health Insurance," written by its president, John C. Goodman, and Gerald Musgrave, a former Stanford economist who now does private consulting. Their investigation is a cold shower for anyone attracted to the sort of health care systems operating elsewhere.

Take a myth, any myth. Other countries spend less on health care? Most of the difference stems from the fact that the U.S. is wealthier than most countries and that as people grow more affluent they devote a bigger share of their spending to health care.

Our costs are soaring out of control? During the 1980s, Goodman and Musgrave found, health care spending rose faster in 11 of 15 advanced countries than in the United States. Among those who did worse than we did were such health care models as Canada, Britain and Germany.

The health of Americans is worse than that of other Westerners? There's some truth here, but the reasons have little to do with medicine — crime, poverty, teen pregnancy and assorted unhealthy habits. Where medical treatment can make a difference, though, the United States does very well.

"For premature babies, for children born with spina bifida or for people who have cancer, a brain tumor, heart disease or chronic renal [kidney] failure," says the report, "the chances of survival are best in the United States." The United States treats more people for kidney failure, as a percentage of its population, than any other Western country. It installs 20 times more heart pacemakers per capita than Canada.

Other countries may proclaim a general right to health care, but their citizens often find that they don't have a right to anything specific. If you need heart bypass surgery in Canada, you may wait five months. For a cataract operation, it may be a year. Britain has more than a million people waiting for surgery. In both places, it's not unusual for people to die waiting for the operation that would save them.

Since old people need the most medical care, you might think they would gain the most from national health insurance. In fact, they tend to be the ones who get shafted. The United States performs twice as many heart bypass operations as Canada — but four times as many for people aged 75 or older. If you're over 65 in Britain and need kidney dialysis, you'd better draft a will.

In fact, if you're old and not perfectly healthy, the United States is among the best places to be. Medical care is only a minor factor in the life expectancy of young people, but it's a major one for old people. In life expectancy for 80-year-old males, the United States is second among the advanced nations, behind Iceland; for women, it trails only Iceland and Canada.

The U.S. system is supposed to be singularly cruel to the destitute, but Goodman and Musgrave amass considerable evidence that in countries with national health insurance, politicians cater to the middle class. "In general," they write, "low-income people in almost every country see physicians less often, spend less time with them, enter the hospital less often and spend less time there" than those who are not poor.

Our system, despite its shortcomings, does ensure that the poor get in the hospital door, through Medicaid and public hospitals. Once inside, they benefit from the most advanced medical care in the world — of the sort that even well-to-do patients in places like Britain are routinely denied. Goodman and Musgrave make it plain that the main reason foreign health care systems look so good is that they're so far away. The U.S. system can stand some improvements, but anyone who thinks national health insurance would improve it is likely to get a surprise. ▲

*Stephen Chapman is a columnist for the Chicago Tribune, where this article originally appeared. It is reprinted with permission.*



## A job well done

As a member of the Illinois State Medical Society, I just received my copy of the informational packet ti-

tled, "A Physician's Guide to Advance Directives." I found the materials to be well-written and full of valuable information. I wish to express my sincere thanks to you for a job well done.

I have been the medical director of a south suburban Chicago hospice for the past 10 years, and I can assure you that we will put these packets to good use.

Congratulations and thank you!

Michael J. Blend, Ph.D., D.O.

Associate Director

Division of Nuclear Medicine  
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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

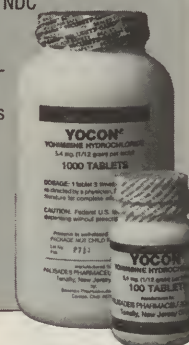
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

## References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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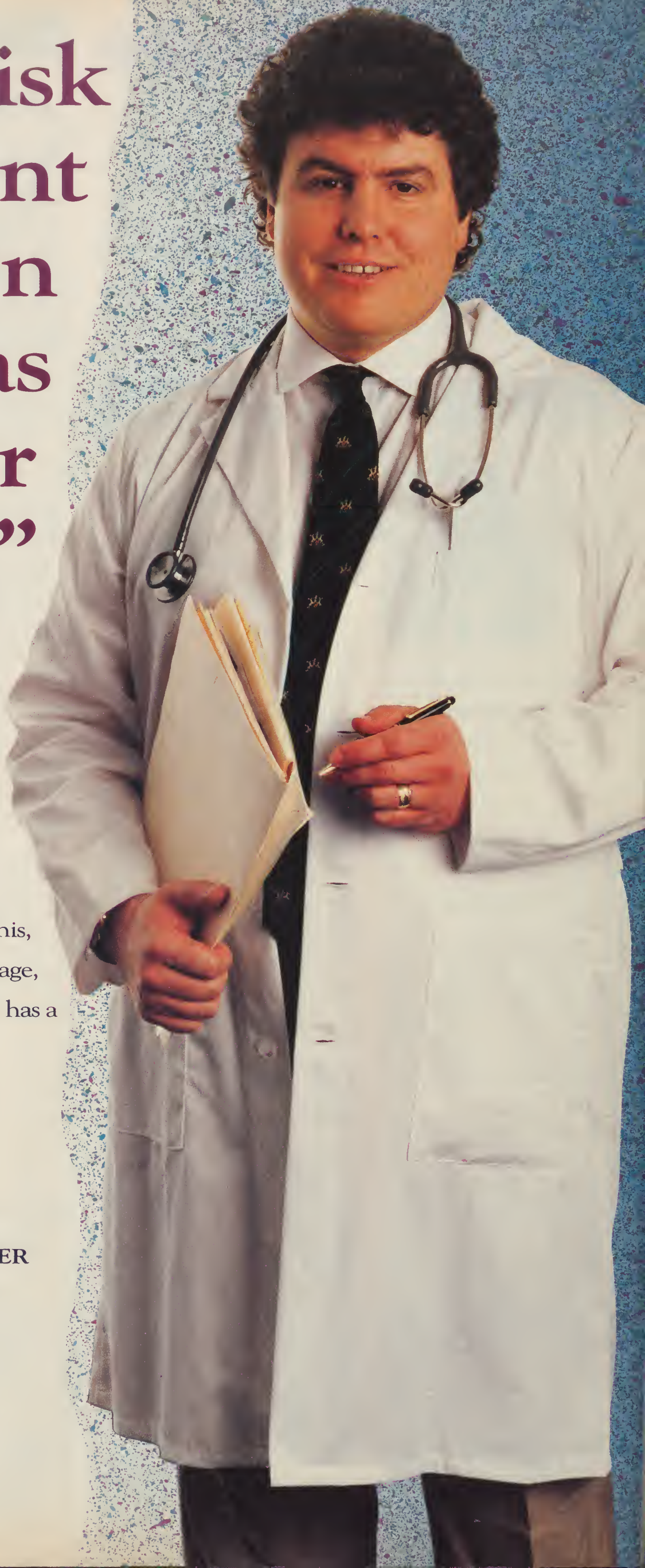
"I had just attended an ISMIE risk management seminar that dealt with the symptoms of cancer most commonly overlooked or misdiagnosed. Information presented at the seminar prompted me to ask questions that did not pertain to the patient's presenting complaint. Because of this, I was able to detect the cancer in an early stage, surgery was performed, and the patient now has a very good prognosis."

- John V. McInerney, D.O.

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# Exchange risk management seminars help physicians diagnose cancer, control stress

by Anna Brown

TWO HIGHLY SUCCESSFUL risk management seminars that help physicians take control of their lives and practices are going on the road again.

"Our programs focusing on cancer detection and diagnosis and on relieving the stress of malpractice litigation have been so well-received that we are offering them again," said Harold L. Jensen, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors.

"Malpractice Dilemma: Focus on Cancer Detection and Diagnosis," to be presented April 29 at the Hyatt Regency Hotel in Oak Brook, will cover detection and the role of mammography in breast cancer; identification and treatment of cervical cancer; screening and treatment of colon cancer; and early detection of prostate cancer, a new topic added especially for this series.

"With the increase of malpractice claims alleging failure to diagnose

and delay in diagnosis of cancer, the Exchange is taking steps to help physicians protect themselves and their patients from diagnostic errors," said program moderator Jere E. Freidheim, M.D., chairman of the Exchange Risk Management Committee and clinical assistant professor of pediatrics at the University of Chicago Hospitals.

Physicians, defense attorneys and administrative and clinical health care professionals involved in risk management are encouraged to attend the daylong seminar. In addition to Dr. Freidheim, speakers include Alfred J. Clementi, M.D., general surgeon and member of the Illinois State Medical Insurance Services Board of Directors; Robert M. Craig, M.D., associate professor of medicine at Northwestern University Medical School; Leon Dragon, M.D., chief of medical oncology at St. Joseph Hospital and Health Care Center in Chicago; Kevin Glenn, defense attorney, Clausen, Miller, Gorman, Caffrey & Wittous; Harold J. Lasky, M.D., clinical professor of ra-

diology at the University of Illinois College of Medicine; Arnold Wagner Jr., M.D., associate clinical professor of obstetrics and gynecology at Northwestern University Medical School; and W. Bedford Waters, M.D., associate professor of urology at Loyola University Medical Center.

The program has been approved for six prescribed CME hours by the American Academy of Family Physicians and six hours of credit in Category 1 of the Physicians' Recognition Award of the American Medical Association.

## From 'coping' to 'taking control'

The successful "Coping with the Stress of Malpractice Litigation" seminar presented last fall is being repeated this spring under the new title, "Taking Control: Managing Your Malpractice Lawsuit."

"We wanted the seminar's title to reflect the Exchange's strong conviction that physicians can do more than merely react to the litigation experience," said James P. Ahstrom Jr., M.D., chairman of the Ex-

change's Physician Support Group. "They can become staunch advocates for themselves; they can become active participants in determining the direction of their case; they can – in short – take control."

The first presentation will be May 6 at the Lincolnshire Marriott in Lincolnshire, with future seminars scheduled for Sept. 9 at the Oak Brook Hyatt in Oak Brook, and Oct. 21 at the Collinsville Holiday Inn in Collinsville.

Participating physicians will receive two hours of Category 1 CME credit of the Physician's Recognition Award of the American Medical Association.

Speakers will describe the discovery process of malpractice litigation, defend or settle issues and the trial experience. Participants will discuss general concerns about stress and the litigation process with panelists. Dr. Ahstrom will moderate the presentation. Other panelists include Exchange staff representatives and Exchange defense attorneys.

To obtain registration materials for either "Malpractice Dilemma: Focus on Cancer Detection and Diagnosis," or "Taking Control: Managing Your Malpractice Lawsuit," contact the Exchange risk management department at (312) 782-1654 or (800) 782-ISMS. ▲

## CASE in POINT

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin

### Case #1

**Presenting complaint and initial diagnosis** – A 55-year old man went to an orthopedic surgeon complaining of severe back pain. The man had seen his family physician for routine checkups over four years. The physician had noted and charted changes in the size and firmness of the prostate, but did not inform the patient. He did not work up the patient to rule out prostate cancer or refer him to a urologist.

**The case in brief** – The surgeon performed x-rays and a bone scan and diagnosed advanced prostate cancer with metastasis to pelvic and vertebral bone. Surgery and chemotherapy followed, but the patient's prognosis was poor.

**The resulting claim** – The patient sued the family physician for failure to diagnose and aggressively treat, contending that his cancer would have been treatable if it had been diagnosed and treatment initiated at the time the physician noted that the prostate was becoming firm. The defendant physician argued that since no prostate nodule had been palpat-

ed, a diagnosis of benign disease was appropriate.

**The outcome of the claim** – A jury returned a \$1 million verdict for the plaintiff, who died a few days later.

### Case #2

**Presenting complaint and initial diagnosis** – A 43-year-old man consulted a cardiologist, complaining of swollen, painful legs with secondary groin varicosities. He had no complaints of urinary tract difficulty or of pain anywhere else. The physician suspected deep vein thrombosis of unknown etiology.

**The case in brief** – The patient was admitted to a hospital and a work-up for occult malignancy to explain the patient's deep vein thrombosis was done. The patient's alkaline phosphatase and CEA levels were slightly elevated. A barium x-ray was negative. CT scans of the pelvis and bones were interpreted as normal; a CT scan of the abdomen showed mild enlargement of the liver and spleen. No digital rectal examination was performed. The physician noted in his office records that the evidence of malignancy was "nil." The patient was discharged and anti-coagulants prescribed. Six months later, the patient returned complaining of dysuria and bladder dysfunction. A biopsy of the prostate revealed moderately differentiated adenocarcinoma of the prostate, stage D-2. A transurethral resection was performed and chemotherapy administered, but the patient died seven months later.

**The resulting claim** – The patient's spouse sued for failure to diagnose cancer and failure to perform a digital rectal examination, which would have revealed the presence of cancer earlier; failure to consult with a urologist; and failure to aggressively follow up abnormal test results.

**The outcome of the claim** – The case was settled for \$410,000.

### Case #3

**Presenting complaint and initial diagnosis** – A family physician referred a 62-year-old man to a urologist because he had found a prostate nodule during a routine examination.

**The case in brief** – The urologist recommended that a biopsy be performed. Eight biopsy specimens were taken, all of which were reported as benign. One acid phosphatase test showed a slightly elevated level; it was then repeated and reported as normal. The physician, however, advised the patient to have a repeat acid phosphatase test in three months. The patient did not return for almost two years, at which time the physician found that the prostate was diffusely hard. A repeat biopsy confirmed the malignancy and acid phosphatase levels were elevated. The urologist advised the patient that his options were pelvic lymph node dissection and possible radical prostatectomy or radiation and hormone therapy. The patient opted to go to another medical center where he underwent a pelvic lymph node dissection followed by radiation and hormone treatment. He died 18 months later.

**The resulting claim** – The patient's wife sued for failure to diagnose and failure to communicate with and follow up on the patient, resulting in his death.

**The outcome of the claim** – A jury ruled in favor of the defendant physician.

**The points these cases make** – The incidence of prostate cancer now surpasses that of lung and colon cancer in males, says W. Bedford Waters, M.D., associate professor of urology

at Loyola University Medical Center in Maywood. "There is an increasingly higher incidence of prostate cancer in patients in the 50 to 60 age group, and even in patients in their 40s." Dr. Waters suggests steps physicians can take to assure that prostate cancer is diagnosed early and appropriate follow-up measures are initiated:

- Take a thorough patient history. If a man has a father, brother or uncle who had prostate cancer, the chances are three times as great that he will develop it.
- Perform an adequate digital rectal examination annually on all men over the age of 40.
- If an abnormality is found, the patient should be referred to a urologist. "Abnormalities might include an enlarged prostate gland, a firm gland that might be suggestive of cancer, or a distinct nodule," says Dr. Waters.

(continued on next page)

## Two copies? Pass one on to a colleague

IF YOU RECEIVED more than one copy of the brochure describing the upcoming Illinois State Medical Inter-Insurance Exchange cancer detection and diagnosis seminar, you are not alone. Policyholders received multiple copies of "Malpractice Dilemma: Focus on Cancer Detection and Diagnosis" in error. We apologize for the inconvenience, but ask that you consider passing along your extra copy to a colleague who might also benefit from attending the program. ▲



## Department of Central Management Services shortfall figures for fiscal 1988-1992 (in millions)



Source: Illinois Department of Central Management Services  
\* DCMS projection

## State reimbursements

(continued from page 2)

payment up front.

Officials of the American Federation of State, County and Municipal Employees say that provisions of the Illinois Prompt Payment Act requiring DCMS to pay 2 percent interest on past due bills should preclude going directly to employees. "When providers take assignment of benefits, they are eligible for the 2 percent. Providers can get interest and employees cannot," said Hank Scheff, director of budget and benefits analysis at AFSCME. The union represents 52,000 state employees.

Flaherty said, however, that the 2 percent interest is not that useful when "the cash is needed now to cover cash flow."

As part of last year's budget agree-

ment, state employees were required this year for the first time to make monthly contributions for health insurance. These contributions range from \$5 to \$12.50, based on salary level, with employees making under \$20,000 paying nothing. "It is such a marginal amount of money," said Scheff. "It's not even close to closing the gap." Employees have always been required to make contributions for dependent coverage.

Rep. Michael D. Curran (D-Springfield) has urged Gov. Edgar to transfer \$15 million from other sources and borrow an additional \$135 million to pay the backlog of bills. The governor, however, has said he will not borrow money unless there is a specific payback plan, a similar condition he imposed when he agreed to borrow money to pay past-due Medicaid bills. ▲

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## Case in Point

(continued from page 7)

• Studies should include a prostate-specific antigen test, prostatic ultrasound and a biopsy.

• If prostate cancer is diagnosed, a bone scan and a pelvic CT scan should be done, a new PSA test performed, and an acid phosphatase done to rule out stage D-O disease. The tumor should be clinically staged so that appropriate therapy options can be discussed with the patient.

"A patient can have metastatic disease in the face of a normal acid phosphatase," says Dr. Waters. "In some cases, the tumor is so undifferentiated that it doesn't make acid phosphatase."

• If tests are negative, the physician should inform the patient that follow-up is necessary on a regular basis, at least annually. Follow-up should include a repeat PSA test, ultrasound and sometimes a repeat biopsy. "We have such patients come back in three to six months for a repeat biopsy," says Dr. Waters.

• Although it is theoretically the patient's responsibility to seek follow-up visits, use of some kind of tracking and recall system is a protective measure for the physician. "Computers make this easier to do today," suggests Dr. Waters.

• Carefully note all findings in the patient's chart each time he is seen.

"Sometimes prostate changes are very subtle – a slight induration, uniform firmness or a distinct nodule. These are signs to watch for," Dr. Waters stresses.

As many as 130,000 new prostate cancer cases are detected each year, partly because people are living longer, but also because diagnostic techniques are improving. "PSA tests alone are picking up a large number of such cancers in the early stages," the Loyola faculty member says. "Even so, there are 25,000 to 30,000 deaths each year. Prostate cancer has a very good prognosis if found early, nodes are negative, the tumor is confined to the prostate and appropriate treatment initiated. The five-year survival rate is 93 percent and the 10-year survival rate is 60 percent to 70 percent." ▲

Carol Brierly Golin is publisher of Medical Liability Monitor.



# Community efforts increase access for medically underserved

by Tamara Strom

REFUSING TO WAIT for a consensus on how to solve the nation's health care crisis, several Illinois communities have recently taken matters into their own hands by opening clinics to provide access to medically underserved Illinoisans. Two such efforts are an obstetrical clinic in Springfield and a primary care clinic in Waukegan.

The Springfield Department of Public Health, with help from the Illinois departments of Public Aid and Public Health, opened a clinic Feb. 3 to provide comprehensive obstetrical care for Medicaid-eligible women. The Women and Infants Health Services Clinic, staffed by a certified nurse-midwife and volunteer physicians, offers OB care from prenatal visits through post-partum care, including nutritional counseling and parenting training. Infant care also is available.

Patients will be treated by the nurse-midwife, under physician supervision by the three obstetricians of Women's Healthcare Ltd., a Springfield OB practice. The clinic plans to hire another nurse-midwife as soon as possible, with estimates about the number of annual patients swelling to between 600 and 700.

Every patient will be seen by one of the obstetricians at least once during her pregnancy, and the physicians will perform all deliveries, said Brian Letourneau, director of the Springfield Health Department.

"The clinic came about as the result of an alarm bell – high infant mortality," Letourneau said. "The issue is access to care. We needed to take action ourselves."

"This is the first clinic of its kind in the state," said IDPA Director Phil Bradley. IDPA loaned the city \$25,000 to start the clinic, which will be repaid through withholding of the clinic's Medicaid payments. "In short, it means we can reach out to pregnant women who previously had a hard time finding medical care in



Patient Lawanna Holmes (left) of Springfield gets prenatal care from certified nurse-midwife Bonnie Schmid at Springfield's Women and Infants Health Services Clinic. ▲

the area. Now they can get that care at a city-run clinic."

## Community gets behind clinic

With unemployment rates rising in North Chicago, Waukegan and Zion, more and more families are without health insurance. So government officials, business leaders and health care providers, including the Lake County Medical Society, got together in September to plot strategy to create HealthReach, a clinic for the medically indigent.

"In less than six months, we've come quite far," said Sister Christine Bowman, O.S.F., administrative assistant at St. Therese Medical Center in Waukegan and president of HealthReach. "We'll be able to see our first patients by May 1. It's truly a community effort. The clinic has generated a lot of interest and people are very willing to give."

The purpose behind establishing the clinic was threefold: to expand access to the medically underserved, or "working poor"; to increase the

health of the community through wellness promotion; and to provide an arena for volunteerism. The clinic will be staffed by volunteer physicians, nurses and translators, Sister Bowman said, adding that a number of area physicians have already called to donate their time and services. She stressed, however, that more doctors will be needed keep the clinic operating at full capacity. The clinic needs physicians to see patients on-site and to accept referrals for surgical care and management of complex cases.

For patients requiring hospital care, St. Therese Medical Center and Victory Memorial Hospital will provide free care. Sister Bowman said clinic officials hope other area hospitals will also agree to accept medically underserved patients at no cost to help spread the cost among as many institutions as possible.

"The clinic will enable us to address people's health care needs before they become more serious and costly," Sister Bowman said. "Because many people don't have access to primary care, they use the emergency room for care when their illness becomes serious. That is the costliest point of entry into the health care delivery system. We hope to decrease costs by providing care in a timely manner." ▲

— Anna Brown contributed to this story.

## ISMS selects March-April Employees of the Month

by Tamara Strom

WHEN IT ABSOLUTELY, positively has to get there, Illinois State Medical Society staff members call Derrick Goard and Acie Cheairs, who run the Society's mail room.

And in the first dual presentation of the ISMS Employee of the Month Award, Derrick and Acie were cited for their teamwork, competence and attention to detail in keeping parts of the Society's communication system on track. Acie was honored as the March Employee of the Month and Derrick was cited as the April award winner.

"Every organization that has a mail room needs competent individuals to staff it," said Diana Role, Illinois State Medical Insurance Services vice president of management and computer services, during the March 2 award presentation at the Society's headquarters in Chicago.

"Not only do they run an extremely efficient operation, they do so with attention to detail and service that is a model for their colleagues throughout ISMS," Role noted.

As a team, Derrick and Acie received several nominations for the award, Role said, prompting the Employee of the Month nominating committee to opt for the unusual double ceremony.

"They are a team within a team," she said. "They complement each other's strengths and are stronger for their team approach to their work."

As Employees of the Month, Derrick and Acie each received a recognition plaque and a monetary award of \$200. Their names will be added to a special plaque hanging in the Society's reception area.



"Team within a team" Derrick Goard (left) and Acie Cheairs were selected ISMS' March and April Employees of the Month. Goard and Cheairs operate the Society's mail room.

Among the characteristics nominators cited to illustrate why Acie and Derrick deserved the award were their friendliness and willingness to help – especially in creatively solving unique mailing problems. "Staffers turn to Acie and Derrick to figure out how to get it done without increasing costs or staff labor," Role said of their efforts. "They bring a positive, 'can do' attitude to everything they do."

Acie has served as mail room supervisor since joining ISMS in September 1989. Derrick began his tenure at the Society in February 1989 as a file clerk, but soon transferred to the mail room and was promoted to senior clerk in February 1991.

"It's a great honor," Derrick said of his Employee of the Month selec-

tion. "Especially by starting out as a file clerk and then being promoted, it feels good. I feel like people know us and our work. With so many nominations that we both got, people obviously recognize the quality of the work we do and the service we provide for them."

Acie thanked other ISMS staffers for supporting him and Derrick. "Without all of you guys supporting us, we couldn't do it," he said. "Without your help it wouldn't get done."

All permanent, full-time ISMS/ISMS employees – except those at senior management level – are eligible for the award. Physicians who wish to nominate a staff member for the Employee of the Month Award should call the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ▲

## Annual meeting

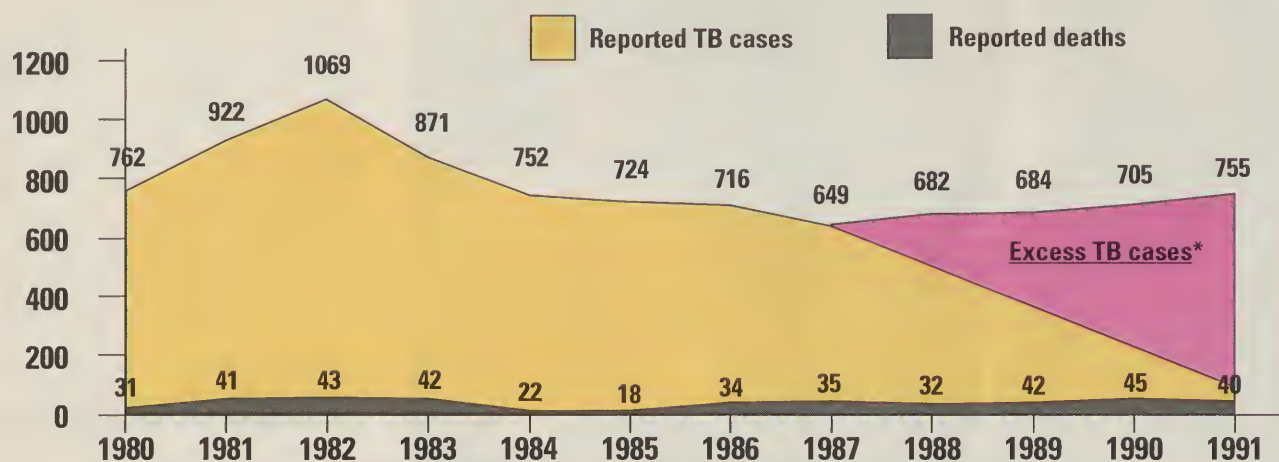
(continued from page 1)

Bloomington, will address the House as ISMS president for the final time. Dr. Reardon will be honored Friday evening for his yearlong tenure as the Society's official spokesman during the annual President's Night reception and dinner. Entertainment will feature pianist Prof. Barrington Coleman, director of the Illinois Wesleyan University School of Music, in a program titled, "Limited Edition – Jazz & Vocal Sounds." The John Hunt Orchestra will provide music for dancing.

ISMS President-elect Arvind K. Goyal, M.D., of Rolling Meadows, will be sworn in as the Society's president on Sunday morning, and at that time will address the House outlining his plans for his year as the spokesman for the 18,000 physician members of ISMS. Before its scheduled noon adjournment on Sunday, the House will elect ISMS officers, trustees and delegates to the American Medical Association to serve for the coming year. ▲



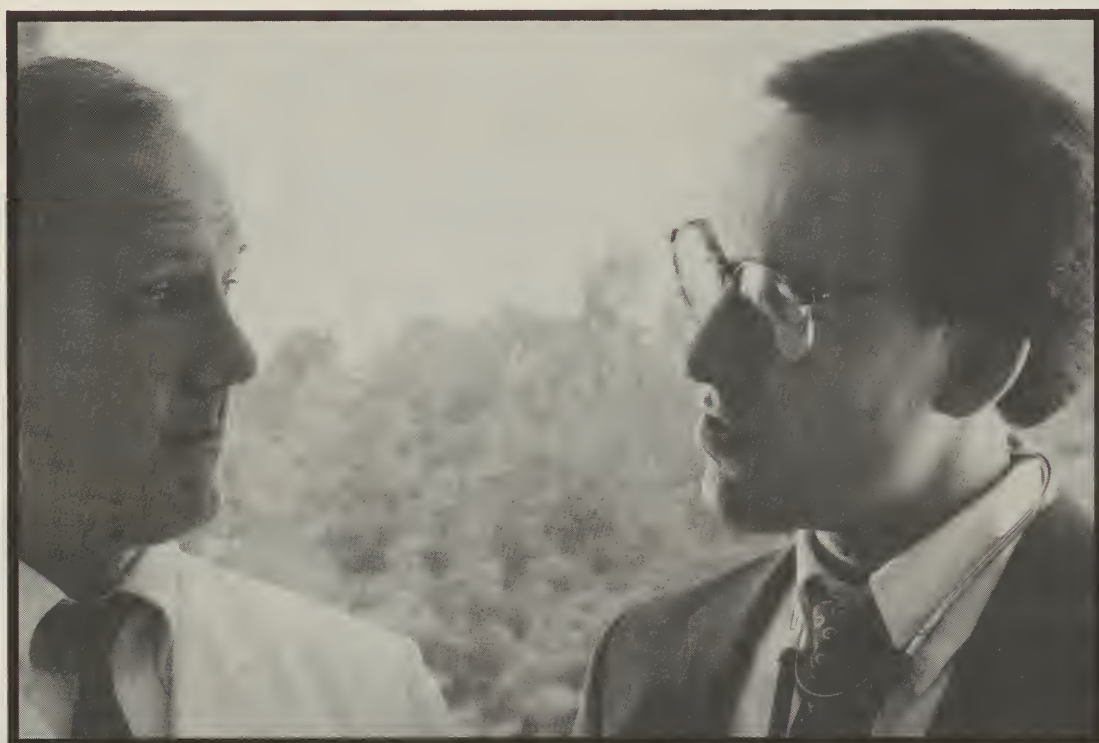
# TB morbidity and mortality in Chicago, 1980-1991



Source: Chicago Department of Health

\*Cases of TB attributed to new outbreak. Prior to 1987, TB had been steadily declining.

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## TB

(continued from page 1)

rates of 120.7 and 101.9 cases per 100,000 people, respectively. "This is 10 times the national average of 11 cases per 100,000 people," Kuharik said. "In some neighborhoods TB is at epidemic proportions. It's the same as some Third World nations."

Chicago's TB cases account for about 63 percent of Illinois' total TB caseload. Nearly 1,200 cases were reported statewide in 1991.

Public health officials attribute some of the rise in TB to the growing numbers of people with AIDS, since the at-risk populations for the two diseases overlap. "One of the most dramatic and serious increases in TB is among AIDS patients," Kuharik said, citing a 200 percent increase in TB in people with AIDS.

The growing elderly population also contributes to the increase, public health officials say. "AIDS patients, HIV-infected drug users and the elderly are more susceptible to tuberculosis because their immune systems are weaker than those of healthier people," according to the Illinois Department of Public Health. "People over the age of 65 account for nearly 28 percent of the tuberculosis cases, although this age group only makes up about 12 percent of the population."

*"In some neighborhoods TB is at epidemic proportions. It's the same as some Third World nations."*

Another "disturbing" TB-related trend is the appearance of drug-resistant TB strains in Chicago, Kuharik said. Other states experienced this rise in drug-resistant TB earlier than Illinois, but Chicago saw 13 cases in 1991. Only two of these cases were found in immunocompromised patients, Kuharik explained.

To stem the rise in TB, Chicago health officials are launching a TB control plan that will increase screening and administration of preventive treatments among at-risk populations. "We want TB screening and prevention to become part of ordinary primary care, and not just widespread skin testing to see who is infected; we know people are infected," Kuharik said.

Specifically, the TB control program will target selected schools, HIV-infected patients and the homeless, among others. Testing and treatment will be given and monitored at homeless shelters, Kuharik said.

Physicians working in hospitals and clinics, as well as those in private practice, have a prominent role in halting the spread of TB, Kuharik noted. "Physicians need to recognize if their patients are in those risk groups for TB, and then test them and provide them with preventive therapy," he said. "If any doctors are currently treating patients with TB, they need to do sensitivity testing to make sure the patient does not have a drug-resistant type." ▲



## Past president

(continued from page 1)

dent's Tour, he says many of the medical issues that dominated his presidency are still with us today.

"The major issue in 1952-53 was [the physicians'] efforts to protect [themselves] from government interference," he says. "We were threatened with socialized medicine. We resisted that, but with President Lyndon B. Johnson, we got socialized medicine anyway. We just called it Medicare."

During his year as president, Dr. Sweeney toured county medical societies to talk about "what was going on in medicine." He says another major issue then that still sparks heated discussion among today's ISMS members was AMA unified membership. Because Illinois is a unified state, physicians belong to the American Medical Association, together with membership in ISMS and their county medical society.

"Many doctors were against it and said, 'The AMA never did anything for me,'" recalls Dr. Sweeney, a strong advocate of unification. "But one individual in Washington has no power. We need the powerful AMA in order to meet with the people who make the laws we don't like and keep them from getting any worse."

Dr. Sweeney acknowledges that although many of the issues of 40 years ago still cause controversy today, the medical profession as a whole has changed significantly. These changes include the advances in medical technology, increased availability of drugs and improvements in laboratories, he says.

He laments the other changes in recent years – such as increasing governmental influence, the rising cost of health care and increased malpractice threats – that have made the physician "less of a family friend to the patient." Dr. Sweeney says that when he entered the medical profession the status of the physician in the community was "equal to priests and clergymen."

### Physicians' role in society improved

Dr. Sweeney believes, however, that the role of physicians in society has improved and will continue to improve as doctors "take more interest in politics and public relations to help protect the profession." He says that was his message in 1952, and that he still believes in it.

"I believe that [medical society] involvement had a value then and certainly is important, if not more important, now," says Dr. Sweeney. "I believe in the private practice of medicine and the efforts to resist government influences."

The oldest of six children, Dr. Sweeney was born in Ardoch, N.D., in October 1899. Encouraged by his mother, he entered and completed his first two years of medical training at the University of North Dakota School of Medicine and received his medical degree from Loyola University's Stritch School of Medicine in 1924. He interned at Mercy Hospital in Chicago, and was on staff at the Illinois Eye and Ear Infirmary, Little Company of Mary Hospital, Roseland Hospital and St. Francis Hospital on Chicago's South Side.

Dr. Sweeney began his involvement in organized medicine in 1926 at a time when medical society membership was a requirement for hospi-

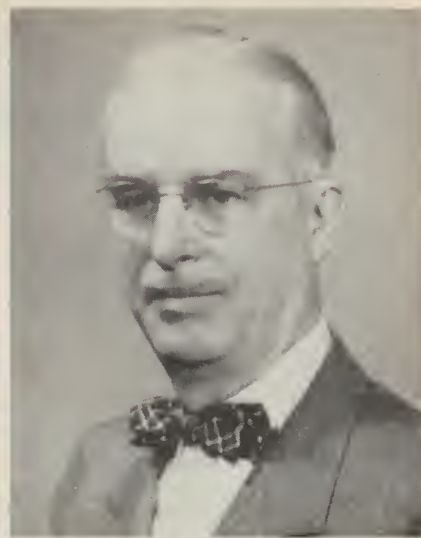
tal affiliation. After serving as councilor for the Calumet branch of the Chicago Medical Society, he was elected an ISMS trustee and then spent five years serving in World War II. A retired colonel with the Army Medical Corps Reserve, Dr. Sweeney was awarded three Bronze Stars, the Legion of Merit and French and Italian decorations for his service. He returned to Illinois in 1946 and was elected to the AMA's House of Delegates, a position he held until 1959.

In 1980, after 54 years in practice, Dr. Sweeney retired. He now resides in Ft. Lauderdale with his son.

Dr. Sweeney says that although medicine today is much more technologically advanced than in his day, he would still give it another try because, "The basic desire is still there – to be a physician and help take care of the sick and wounded." ▲



Photo: Al Sides



Left: Dr. Sweeney relaxes in his Ft. Lauderdale home, where he has lived since he retired from active practice in 1980. Right: Dr. Sweeney as ISMS president in 1952.



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**Lab rules**  
(continued from page 1)

with staggered deadlines; however, the section that will allow the Health Care Financing Administration to collect fees goes into effect at the end of March. HCFA is the government agency responsible for CLIA oversight. (See chart below for fees.) Under the federal law, all physician office labs – regardless of the number or type of tests performed – must register with HCFA. As of Sept.

1, no office lab may perform a clinical test of any kind without a CLIA certificate of waiver or registration. Each office lab that completed a HCFA lab survey last fall will receive a CLIA application form sometime in May. Physicians should carefully review the information on the form and correct any inaccuracies. These applications will aid physicians in determining what category their laboratory falls into – waived, moderately complex or highly complex. Physicians performing only those

clinical tests falling into the waived classification may apply for such a certificate, exempting them from routine government inspections. The eight waived tests are: dipstick/tablet urinalysis, ovulation tests, urine pregnancy tests, non-automated erythrocyte sedimentation rate, hemoglobin, fecal occult blood, spun micro-hematocrit and blood glucose testing only with glucose monitoring devices cleared by the Food and Drug Administration for home use.

The completed application must be returned to HCFA within 30 days with the appropriate certification fee: \$100 for a waived class certificate and \$100, \$350 or \$600 for registration certificates.

Physicians who did not complete the HCFA survey last year must request an application and return it

promptly. Physicians can obtain the necessary survey forms from ISMS, IDPH or the regional HCFA office. Any office lab operating without registering with the government will be in violation of federal law. Once applications are returned, HCFA will issue a 10-digit CLIA number to each physician for use in billing lab tests. After Sept. 1, reimbursement for lab services will be denied for Medicare claims submitted without a CLIA number. Physicians will not be able to bill for lab services under Medicare unless they have signed up with HCFA. Labs performing highly complex tests (such as Pap smears) will be required to satisfy CLIA quality control mandates beginning Sept. 1. Labs offering moderately complex tests will be subject to quality control requirements over a two-year phase-in period. ▲

**CLIA fees vary with number, complexity of tests**

The registration and inspection fees physicians must pay to comply with the new federal regulations governing the Clinical Laboratory Improvement Amendments of 1988 differ, depending on the number of tests performed each year and the complexity of those tests. The following list should provide physicians with a gauge for the fees they will be assessed to continue offering laboratory services in their offices for their patients. (Note: Inspection fees may vary.)

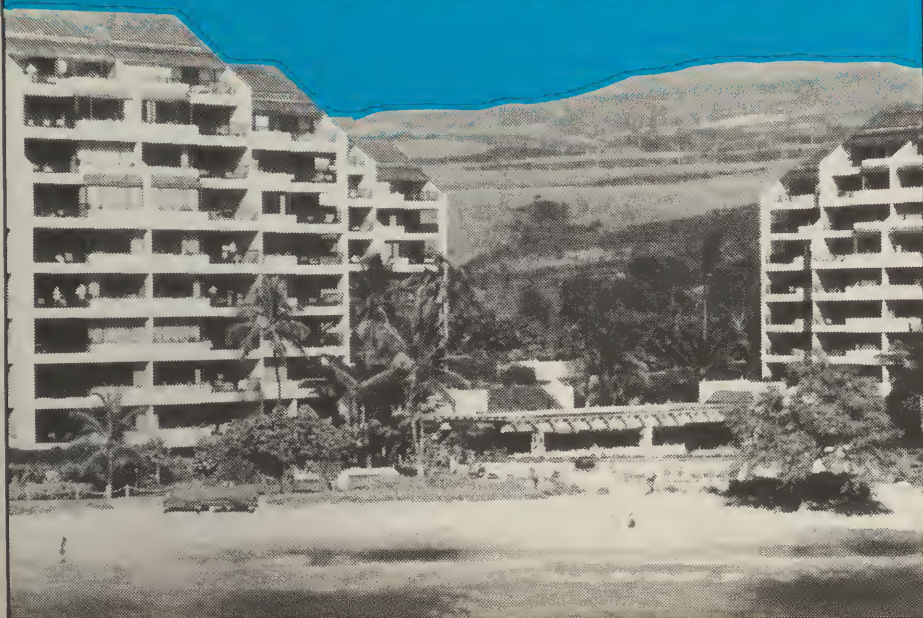
- **Schedule A, low volume:** Not more than 2,000 tests annually. \$100 for registration and certificate fees, \$300 for biennial inspection.
- **Schedule A:** No more than three specialties of service with annual volume of more than 2,000 tests but less than 10,000 tests. \$100 for registration and certificate fees, \$840 for biennial inspection.
- **Schedule B:** At least four specialties of service with annual volume of less than 10,000 tests. \$100 for registration and certificate fees, \$1,120 for biennial inspection.
- **Schedule C:** No more than three specialties of service with annual volume of more than 10,000 tests but less than 25,000. \$100 for registration and certificate fees, \$1,400 for biennial inspection.
- **Schedule D:** At least four specialties of service with an annual volume of more than 10,000 tests but not more than 25,000. \$350 for registration and certificate fees, \$1,645 for biennial inspection.
- **Schedule E:** More than 25,000 but less than 50,000 tests annually. \$350 for registration and certificate fees, \$1,890 for biennial inspection.
- **Schedule F:** More than 50,000 but less than 75,000 tests annually. \$350 for registration and certificate fees, \$2,135 for biennial inspection.
- **Schedule G:** More than 75,000 but less than 100,000 tests annually. \$350 for registration and certificate fees, \$2,380 for biennial inspection.
- **Schedule H:** More than 100,000 but less than 500,000 tests annually. \$600 for registration and certificate fees, \$2,625 for biennial inspection.
- **Schedule I:** More than 500,000 but less than 1 million tests annually. \$600 for registration and certificate fees, \$2,870 for biennial inspection.
- **Schedule J:** More than 1 million tests annually. \$600 for registration and certificate fees, \$3,115 for biennial inspection. ▲

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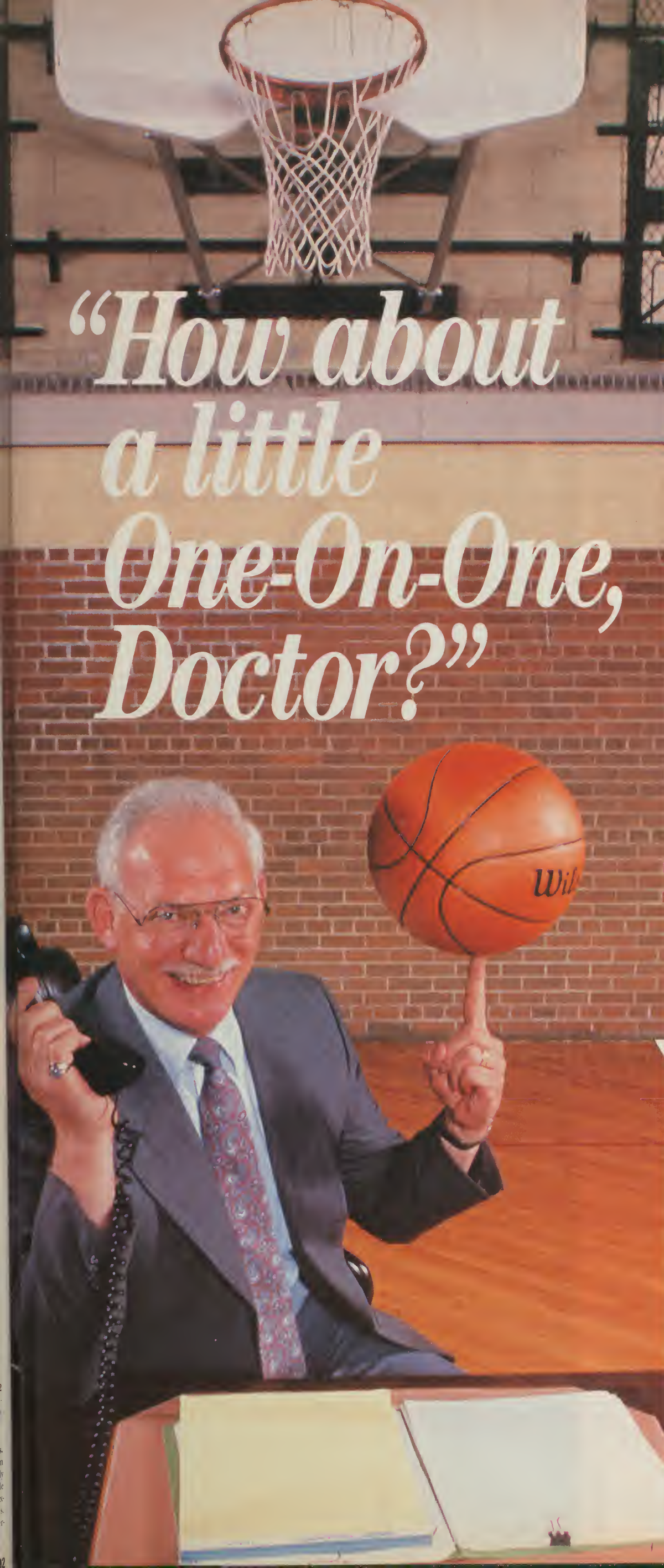
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**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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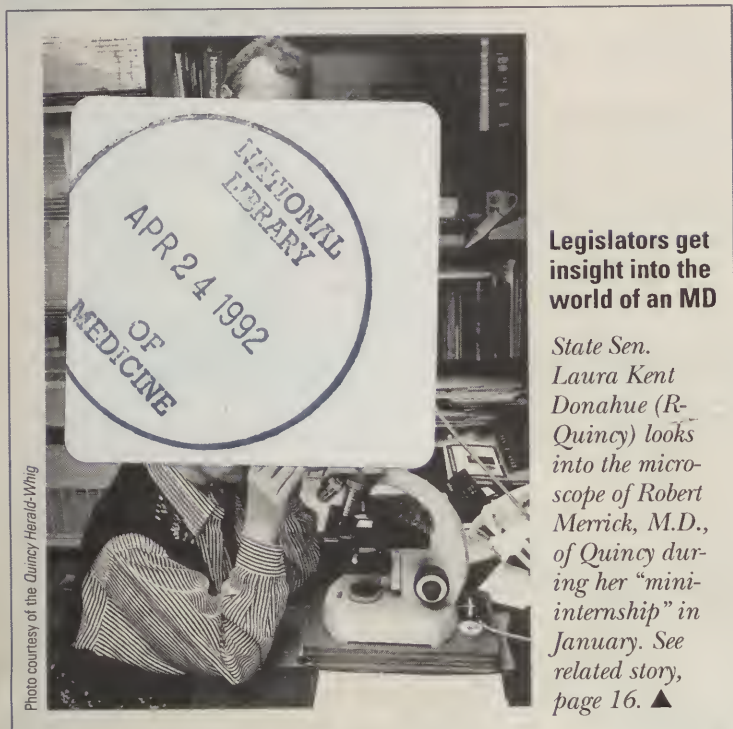


# Illinois Medicine

April 10, 1992

ILLINOIS STATE MEDICAL SOCIETY

Focus on the  
ISMS Physician  
Assistance Program... 10



**Legislators get insight into the world of an MD**

State Sen. Laura Kent Donahue (R-Quincy) looks into the microscope of Robert Merrick, M.D., of Quincy during her "mini-internship" in January. See related story, page 16. ▲

First of a series

## Americans with Disabilities Act provides access, affects physician practices

by Kevin O'Brien

IT IS THE LAW of the land. And experts say the scope of the Americans with Disabilities Act (ADA) will ensure that it touches every American. It certainly will affect in one way or another every physician practicing in the United States.

President Bush signed the bill into law in July 1990. With the promulgation of final regulations one year later, businesses and public and private services of all kinds found themselves scrambling to understand complex and sweeping regulations designed to eradicate discrimination throughout the country against people with disabilities.

Considered the most com-



Amy Rothblatt

prehensive legislation of this kind, the new law goes beyond the provisions of Section 504 of the Rehabilitation Act of 1973, which applied only to federal agencies and private or public agencies that received federal funding. The new law re-

quires U.S. businesses — including medical practices — of all sizes to provide all people with equal employment opportunities and equal access to public services, public places, transportation and telecommunications.

"This is an area that has enormous implications for physicians," says Lei Ann Marshall-Cohen, legal consultant to the National Center for Access Unlimited, a consulting firm specializing in ADA compliance issues. "Access to health care was identified as one of the priorities the law was intended to address."

Consequently, Marshall-Cohen says, with respect to physicians' practices, people with disabilities will draw "a lot of focus and attention. So, some prudent risk management here is advisable."

The law states that "reasonable accommodation" must be made to ensure compliance. This could range from physical modifications, such as ramps and accessible rest rooms for wheelchair-bound patients to providing sign language for hearing-impaired

by Kevin O'Brien

ALMOST 300 Illinois State Medical Society trustees, delegates and alternate delegates from throughout the state are gathering this weekend to debate 87 resolutions affecting ISMS organization and the practice of medicine in Illinois. Though not a record number of resolutions, officials said it is a heavier agenda than in most recent years.

This year's ISMS House of Delegates annual meeting is being held at the Oak Brook Hills Hotel in Oak Brook from Friday, April 10, at 9:30 a.m., through Sun-

day, April 12, after six years in Rosemont.

Reference committee testimony on the resolutions is scheduled to begin at 1:30 p.m. Friday. A special presentation on ISMS budgetary matters will begin in Reference Committee A at 1 p.m. As in past years, any ISMS member may attend and testify at the reference committees. The full House will debate and act on the resolutions all day Saturday and on Sunday morning.

A resolution submitted by the Board of Trustees would amend ISMS bylaws to limit trustee and officer terms. The president-elect and vice presidents would be elected annually and would serve single one-year terms for each office. The secretary-

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**1992**

treasurer, speaker and vice speaker would be elected annually and would be limited to two one-year terms in each office. Current bylaws place no limitations on the number of terms these officers may serve.

District trustees would serve three-year terms, but the number of consecutive terms would be limited to three, with a lifetime maximum of 12 years' service. Any member with current or past service as a district trustee would be limited to 15 years' maximum lifetime service. An exception to this provision allows district trustees already seated at the July 1, 1992 effective date to complete their full term. Current bylaws allow members of the Board of

(continued on page 12)

The results are in...

## Numbers up for Illinois in 1992 residency match

by Anna Brown

IN THE 1992 national residency match, Illinois residency programs filled 1,047 positions out of the 1,274 available slots — a 5 percent improvement over last year's numbers. For the last few years, Illinois match results have been steadily improving. This year's 82 percent fill has brought continued confidence in already fruitful programs, and has renewed hope for some foundering family practice programs. In all, 227 positions are still open.

"This is the best year we've ever had, and everyone involved with recruitment is extremely excited," said Deborah Smith, University of Illinois College of

Medicine at Urbana-Champaign Internal Medicine Residency Program administrator. "We've been improving every year, but this is the first year that we matched

(continued on page 19)



Gregg Daniels

SIU School of Medicine students Anu Natarajan (right) and Theresa Karich receive their match results March 18.

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## Physician, two attorneys jailed in St. Clair County

At press time, *Illinois Medicine* learned that a Belleville physician, an attorney provided by the Illinois State Medical Inter-Insurance Exchange and the physician's personal attorney were jailed April 2 when a St. Clair County judge found them in contempt of court.

Associate Judge James Radcliffe jailed James Vest, M.D., and attorneys Charlene A. Cremeens, who was representing Dr. Vest for the Exchange, and Gerald L. Montroy, Dr. Vest's personal attorney, after Dr. Vest refused to answer a question pertaining to the treatment of a Swansea man who died last year after being treated at St. Elizabeth's Hospital in Belleville. Montroy and Cremeens had advised Dr. Vest not to answer.

In *DeLuna vs. St. Elizabeth's Hospital*, the Illinois Supreme Court Feb. 20 upheld the certificate of merit statute. The law says that when filing a malpractice action, plaintiffs must submit an affidavit from a physician not involved in the case stipulating that the alleged injury or death may have resulted from negligent care.

Montroy told *Illinois Medicine* that Belleville attorney Bruce Cook, who represents the family of Melvin Roth, was trying to "circumvent" the certificate of merit requirement by deposing Dr. Vest under Supreme Court Rule 224. The rule permits a plaintiff's attorney to seek information regarding the identity of individuals who may have knowledge of an alleged actionable claim.

Montroy said that Cook "was trying to obtain information over and beyond that in [eliciting] opinions from [Dr. Vest] regarding his treatment and regarding the treatment of other physicians."

Montroy said no malpractice claim as yet had been filed and that he thought the plaintiff's attorney was attempting to "go fishing."

After being found in contempt, Dr. Vest and the two attorneys were placed in a holding cell at about 2:00 p.m. in the St. Clair County Courthouse for about two hours and then transferred to the St. Clair County jail. They were released about 7:25 p.m. after the 5th District Appellate Court in Mt. Vernon stayed Judge Radcliffe's order pending a hearing. ▲

— by Kevin O'Brien

## Physician Facts

### Tort gushers for 1991

Juries handed down these jackpot tort verdicts last year. The top 10 total comes in at three times the total of just three years ago.

\$127.7 million Chicago	Product liability verdict against drug manufacturer Upjohn Co., alleging that anti-inflammation drug Depo-Medrol caused blindness, which resulted in loss of plaintiff's eye.
\$91.3 million Brooklyn, NY	45-plaintiff consolidated award in case tried against Owens-Corning Fiberglas and other asbestos manufacturers. Same jury still deciding product identification, defendant's culpability and punitive damages.
\$86.5 million St. Louis	Sum of verdicts against Decom Medical Waste Systems, KML Corp., Bunker Resources, Recycling and Reclamation Inc. and Raymond Adams, for accusing plaintiff of bringing AIDS virus into a hospital. Settled amount sealed.
\$84.5 million Houston	Premises liability award against an apartment complex and its management company in case of children drowned and brain-damaged in complex pool. Settled for \$17 million.
\$75 million New York	Product liability case consolidating 36 plaintiffs against the Manville Trust, Owens-Illinois and other asbestos manufacturers.
\$62 million Santa Ana, CA	Insurance bad faith award against Truck Insurance Exchange and Farmer's Insurance Exchange where insurer was accused of failing to pay for insured's legal defense. Judge reduced verdict to \$58 million. On appeal.
\$61.2 million Anchorage, AK	Insurance bad faith case against underwriters at Lloyd's of London for failure to pay a restaurant owner's fire insurance claim. On appeal.
\$47 million Houston	Product liability case against Fibreboard and three other asbestos manufacturers for 275 plaintiffs.
\$35 million Los Angeles	Finding against California for failure to maintain center barrier of interstate highway in case of accident resulting in quadriplegia to a 34-year-old man. Settled for \$15 million.
\$33.8 million Corpus Christi, TX	Product liability award against Merrell-Dow Pharmaceuticals for birth defects allegedly caused by pregnant woman's use of Bendectin.

Note: Excludes civil verdicts against alleged or convicted criminals.  
Source: *Forbes* magazine, Feb. 17, 1992.



### State of Illinois Center holds blood drive

Phlebotomist Doris Todd draws the blood of Lt. Gov. Bob Kustra at a blood drive at the State of Illinois Center in Chicago in February. Judy Asher, a spokesperson for LifeSource, a Chicago-area blood center with 13 donor sites, said LifeSource needs to collect 600 pints of blood each day to maintain an adequate supply. ▲

## Auxiliary addresses current health care concerns at annual meeting

by Tamara Strom

ALTHOUGH punctuated by a chocolate fondue cocktail party, the majority of the Illinois State Medical Society Auxiliary's three-day annual meeting April 8-10 was devoted to studying health care concerns on the public agenda. Among the issues to be covered: the effects of television violence on children and adolescents; the politics of health care reform in Washington, D.C.; and environmental factors affecting progress in the war on cancer.

With its mini-internship program and visits with legislators at the state Capitol, the Auxiliary is active and visible in Illinois politics. Now that ISMS is expanding its influence to the nation's Capitol through its Washington presence program, many auxiliary members were looking forward to an April 10 briefing on the politics of achieving health care reform from Washington insider Doug Richardson.

A 12-year veteran of the Washington scene, Richardson is legislative adviser to the D.C. office of Winston & Strawn, a Chicago-based law firm. Richardson was slated to share his views of the various health care reform proposals floating through the Capitol and their chances for congressional adoption.

A toxicologist and pathologist teaching occupational and environmental medicine at the University of Illinois Medical Center, Samuel Epstein, M.D., was also to address the Auxiliary April 10 on the topic, "Losing the War Against Cancer: Who's Responsible and What to Do About It." Dr. Epstein often serves as a con-

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sultant and expert witness to the U.S. Congress on environmental health concerns. He was scheduled to speak about the correlation between cancer and economic carcinogens, including the toxic hazards of chemical pollutants in the air, water, food and the workplace.

A Stanford University graduate and Minneapolis pediatrician specializing in treating child victims of physical and sexual abuse and neglect, Marjorie Hogan, M.D., was invited by the Auxiliary to address its members April 9 during a special presentation on violence in America. Dr. Hogan indicated she would recount her front-line experiences on how television violence affects children and teenagers.

Not all of the Auxiliary's scheduled annual meeting events were business oriented, however. The group planned a chocolate fondue cocktail party Thursday evening, April 9, to honor the Auxiliary House of Delegates and the ISMS House of Delegates and Board of Trustees, and to take a break from the deliberations of the respective board meetings and House of Delegates sessions.

Auxiliary members at the meeting participated in programs to learn strategies for enhancing the organization's activities. The Auxiliary keynote session billed Priscilla Gerber, president-elect of the American Medical Association Auxiliary, as its featured speaker.

More coverage of the Auxiliary annual meeting, including its election of officers, will appear in an upcoming issue of *Illinois Medicine*. ▲

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# Task force grapples with HIV/AIDS issues

by Tamara Strom

WHAT WAS SUPPOSED to be the final meeting of Gov. Jim Edgar's Task Force on AIDS in Health Care turned into a four-hour struggle by task force members to hone the group's draft recommendations into a workable document. Charged with providing the governor with recommendations for implementing S.B. 999, the compromise HIV/AIDS notification law passed last summer, the group has been working for five months to accomplish its assignment. Most observers agree that S.B. 999 is not a perfect law, but it is a reasonable piece of compromise legislation enacted by the legislature in an atmosphere of extreme concern spurred by reports of a Nokomis dentist who died of AIDS.

But if the task force's March 23 meeting is any indication, Gov. Edgar won't have the group's final recommendations on his desk by the April 1 deadline he set when he established the advisory body in November. "We're not going to make the deadline," task force member Anthony Dekker, D.O., told Illinois Department of Public Health representatives at the meeting. "We all agree something must be done, but the mechanism we've been given by S.B. 999 is unwieldy. There are deficiencies in the current law, but the goal of trying to have reasonable legislation that addresses the needs of the public and the health care worker is an achievable goal."

Although acknowledging the difficulty of its task, the group is committed to producing workable recommendations for the governor. "To just say 'repeal the law' would be a cop-out," said task force member Larry Von Behren, M.D. "As far as coming up with a reasonable report with final recommendations, we're very near closure. The panel definitely has taken a very slow and methodical approach to balance the public's need to know with the individual's rights of confidentiality."

*"The panel definitely has taken a very slow and methodical approach to balance the public's need to know with the individual's rights of confidentiality."*

Assuring confidentiality of HIV-positive patients and infected health care workers has been a major thrust of the task force's efforts. Throughout its deliberations, the 19-member group has walked the delicate line between protecting the interests of both the public and the health care profession. In fact, the task force adjourned its March 23 meeting still committed to the idea that HIV-positive health care workers have the same confidentiality rights as ordinary citizens. In other words, patients who may have been exposed to HIV by undergoing an invasive procedure by an infected health care

worker have the right to know the potential risk and receive all appropriate medical interventions. But, the task force maintains, the identity of the health care worker has no bearing on the case.

In addition, task force members stressed the importance of the state's current law that HIV-positive individuals be anonymously reported to IDPH. "If that basic premise were to change, I'd have a hard time swallowing many of the recommendations we're discussing now," said Dr. Dekker. He indicated that the volun-

(continued on page 21)



Wm. Daniels/The Photo Partners

Larry Von Behren, M.D., (left) and Anthony Dekker, D.O., members of the governor's Task Force on AIDS in Health Care, discussed confidentiality and other issues at what was intended to be the group's final meeting March 23.

## Blue Cross Blue Shield REPORT FOR Illinois Physicians

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(4/10/92)



## Editorial

Some good work  
for the taking

Caring for people who are hurting is a physician's reason for being. It is the prime motivating factor in deciding to invest years in the study of medicine. It is a burning idea that for most physicians transcends the hassles of practicing medicine in an increasingly regulated environment. It is what keeps most physicians going.

More often than we might wish, however, the healer becomes the one who is hurting. That hurt may manifest itself through drug or alcohol abuse. Or a physician may develop serious depression, adversely affecting his or her ability to practice. Some physicians are susceptible to both substance abuse and psychological problems. Others may engage in sexual misconduct, or become physically disabled. For still others, the mere passage of time may leave them unable to practice medicine as they used to, and as they want to.

The Illinois State Medical Society's Physician Assistance Program is based on one premise: Impairment is an illness to be treated with compassion, not a crime to be punished. The program has been helping impaired physicians in Illinois since 1977. In 1987, through a grant from the Illinois State Medical Inter-Insurance Exchange, funds became available for case management services. Since then, nearly 300 physicians have been directly aided through the program.

There is no evidence that substance abuse and addiction is more prevalent among physicians than any other profession. We do know, however, that the recovery rate for physicians is extremely high. And we strongly suspect that, in Illinois, the Physician Assistance Program is a major reason. Elsewhere in this issue, you can read several articles about the program – how it works and how it helps your colleagues. We urge you to do so. Then, we urge you to consider becoming involved.

You can begin by being alert to the warning signs of impairment. If you suspect a colleague may be having trouble, you can take the next step by calling the ISMS Physician HELpline at (312) 580-2499 to talk about your concerns. No one need know your name. Any report of impairment is investigated discreetly and anonymously.

But the ISMS Physician Assistance Committee, which administers the program, warns that impaired physicians never get better on their own, they just get worse. So, if your concerns seem valid, you might decide on your own to talk to your colleague, or a member of his or her family. Or, if that yields little result, you could participate in an intervention. Together with your colleague's friends and family, you can take on the task of trying to force your colleague to confront his or her problem, and to help enable him or her to ask for help.

Even better, you could join colleagues from all over Illinois and volunteer to be trained in intervention and facilitate these vital sessions. Or you can work with the program by learning how to monitor a recovering physician's progress.

We don't suggest that doing any of this is easy. It isn't. It requires the same kind of commitment that drove you to become a physician in the first place. But, as one of the physicians we interviewed for our stories attests, the rewards can be enormous. Helping a healer heal again. Good work if you can get it. And if you want it, you can. ▲



*"I think Scamper was a trial lawyer in a past life."*

## President's Column

The marketing  
factor

When I began my term as president of the Illinois State Medical Society a year ago, I chose education as my theme. Now I am more convinced than ever that Illinois physicians have a unique role to fulfill in the debate on health care reform.

Now I am certain that our right and responsibility as the primary health care practitioner includes an obligation to go beyond education and begin to market our perspective, our opinions and our input to the health care debate.

During the past year I have spoken with hundreds of business and community leaders and hundreds of physicians and auxiliary medical personnel. I have spent time with medical students and residents, and with junior high and high school students considering health care careers. I have been interviewed by scores of reporters and editors for dozens of newspapers and radio and TV stations. I have spent time with legislators in Chicago, Springfield, Washington and even Toronto, listening, learning and sharing the need for medicine's up-front presence in the health care debate.

My belief that we can serve an important educational function has been strengthened by these encounters. I have seen firsthand the misperceptions, honest ignorance and lack of information people perpetuate about physicians and our part in the health care delivery system.

So I end my term as your president convinced that we must move beyond our role as educators. We must become aggressive marketers of medicine's unique perspective on health care. We must actively seek out the grass roots citizenry and the leadership of our hometowns to deliver our message. We must become active partners with the media in getting our message out, and we must forge new partnerships with our legislators to assure that our message is received in Washington and Springfield. Finally, and perhaps most importantly, we must recognize that each and every patient encounter is an opportunity for organized medicine to speak out.

The feedback I received from physicians across the state underscored the importance of this effort. Over and over again I heard them



Robert M. Reardon, M.D.

say, "Bob, when you talk to us, you're preaching to the choir. We need to get this information out to our patients, to our hometown newspapers, to our community. Give us something to give to them."

This weekend, the House of Delegates will discuss several resolutions calling for highly visible and costly public outreach programs to position medicine's perspective in the forefront of the health care reform debate. ISMS is already developing a community- and county-based program that will place speakers in a variety of forums to convey our message. Support materials, including speeches and handouts, will help us convey our message – and those materials can also be used in the physician's office. In addition, the Chicago Medical Society has undertaken the development and publication of a patient-oriented brochure comparing health care reform proposals.

We must begin to think of ourselves as medicine's marketing experts. We must identify opportunities in our own communities where our expertise is needed, and we must aggressively pursue opportunities to get our message out. We must find outlets for our message and our input. No longer can we afford to think of "marketing" as a commercial term inappropriate for use in the learned professions.

We've been marketing health and healthy lifestyles all our careers. It's time to take the next step forward and start marketing our expertise in health care delivery. Because if we don't take on that responsibility, someone else may take it on for us. ▲

Robert M. Reardon, M.D.  
President

## Illinois Medicine

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## Guest Editorial

## Committee helps impaired MDs find help



by James C. Leonard, M.D.

Helping to prevent and recognize physician impairment is the mission of the Illinois State Medical Society's Physician Assistance Committee. Formed in 1977, the committee has been actively developing programs and services to meet its mission. The past year has been especially busy.

One of the committee's primary activities is to oversee and monitor the ISMS Physician Assistance Program. The program aids physicians with all types of impairment, including alcohol and drug abuse, psychiatric disorders and physical impairments. Its purpose is to motivate impaired physicians to seek evaluation and treatment. Program services, provided by the Parkside Medical Services Corp. in Park Ridge, include diagnosis confirmation, intervention, referral to an appropriate treatment program and monitoring after treatment. A successful return to practice is always the primary goal.

Developing criteria to evaluate treatment was one of the committee's major accomplishments in 1991. Forms created by the committee will be used to evaluate the programs and treaters. Our goal is to compile a committee-approved list for the Physician Assistance Program.

An important component of the Physician Assistance Program is conducting interventions. An intervention is a structured process in which the addicted physician is presented with evidence of his or her impairment. The goal is to motivate the physician to treatment. Interventions are conducted by trained physician volunteers who typically work in teams of three to five members, primarily in their own or neighboring counties. More than 80 percent of the time, these interventions successfully break through the physician's denial, enabling the physician to seek treatment.

The Physician Assistance Committee continually recruits physicians to serve as intervenors and holds periodic training workshops. Last month, the committee sponsored a workshop to train physicians in the Peoria area. In addition, a videotape and accompanying materials are available from ISMS to help train those unable to attend a workshop.

The shorter a physician's disability

period is, the better the chances of successful treatment and return to practice. Therefore, early identification of the signs of impairment is crucial. The committee has developed a slide presentation to help physicians, other medical professionals and families recognize the signs and symptoms of impairment. Committee members have already gone on the road with the presentation and are willing to continue doing so for county and specialty medical societies, auxiliary groups, hospital medical staffs and other interested groups who request it.

Experience has shown that the most effective prevention and intervention efforts are achieved through local activities. Helping hospitals form their own committees to assist impaired physicians remains one of the committee's top priorities. An active hospital program raises awareness about the signs and symptoms of impairment and enables concerned colleagues to recognize and effectively deal with situations when indicators of impairment emerge.

Some time ago, the committee published guidelines to assist hospitals in forming their own impaired physician committees. On May 1, 1991, the Illinois Department of Public Health began requiring that medical staffs provide a mechanism to assist medical staff members in addressing physical and mental health problems. We are confident these guidelines can help medical staffs comply with this requirement. The committee is also willing to help hospitals with individual cases.

Prevention of physician impairment is another ongoing concern. Individual committee members conduct stress management workshops for residents, students and physicians. The committee is also seeking to develop other educational programs and materials to help physicians before they become impaired.

It is gratifying to know that our efforts are paying off. I am happy to report that of the physicians who are recovering in the Physician Assistance Program, 95 percent have reentered practice. Physicians, their families and their patients continue to be the winners with this program. When they win, we all win.

But there is still much work to be done. Every Illinois physician can play an active role in the work of the ISMS Physician Assistance Committee. Let your colleagues and others know about our program and encourage its use.

If you suspect one of your colleagues is impaired, don't ignore the problem — have the courage to help. If you think you might want to try to become an intervenor, let us know. But no matter how you choose to do so, get involved. You will find the rewards tremendous. ▲

*Dr. Leonard is chairman of the ISMS Physician Assistance Committee. Copies of the hospital guidelines, intervention videotape and information about the Physician Assistance Program can be obtained by calling the Illinois State Medical Society at (312) 782-1654 or (800) 782-ISMS.*



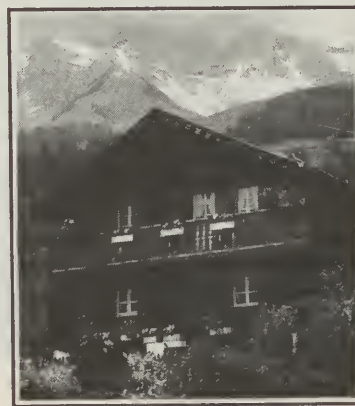
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# CASE in POINT

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin

Because this issue of Illinois Medicine explores the Illinois State Medical Society's Physician Assistance Program and its efforts to aid impaired physicians, we are reprinting a "Case in Point" on impairment that we published in May 1991. This "Case in Point" differs from others in that it is not based on actual claims data. The cases cited are hypothetical, but the problems represented are very real. What do you suspect the problems are?

## Case #1

**The developing scenario** – Over time, the behavior of one of the physicians in your practice changes. Some days he arrives late, talks too loudly, berates staffers for no apparent reason, dispatches patients quickly and leaves early. Other days he is morose and aloof, avoiding any personal conversations.

A colleague complains that the doctor failed to make hospital rounds on the weekend he was to cover for the practice. Nurses say they telephoned his home but his wife said he was ill and sleeping. He no longer participates in community activities.

Late one night he is involved in a car accident, and although police do not ticket him, rumors circulate that he was drunk at the wheel.

## Case #2

**The developing scenario** – A 34-year-old female physician in a small practice becomes noticeably hostile and withdrawn. On occasion she locks herself in her office for long periods of time. Her marriage breaks up and over a six-month period she fires three medical assistants.

She tries to persuade her colleagues to dispense certain drugs from the office as a service to patients. A physician at the hospital comments on her erratic behavior, noting that she gave three different sets of orders for three patients with similar problems.

One night the office is broken into and certain controlled drugs are discovered missing. This prompts a pharmacist to comment to another physician in the practice that, "Dr. X has been using 10 times as much of [a certain prescription drug] as she did last year."

## Case #3

**The developing scenario** – A respected senior physician seems increasingly forgetful. He fails to order indi-

cated tests or to follow up tests he does order. He no longer keeps adequate notes in the charts, despite a hospital warning to keep his records current. His gait seems unsteady.

One night he arrives at the hospital at 2 a.m. to make rounds in a very confused state, slurring his speech. The nursing staff whispers that he is probably drunk.

### The diagnoses:

**Case #1** – Alcohol or drug addiction

**Case #2** – Bipolar mental disorder

**Case #3** – Malignant brain tumor

**The points these cases make** – Each of these physicians is impaired. He or she needs help – help that you and other physicians can provide. An impaired physician who acknowledges that a problem exists, and who completes a treatment program, almost always can be restored to health and return to practice.

Failure of loved ones and colleagues to help set this healing process in motion can jeopardize both the physician and his or her patients. Medical liability suits may also occur, involving not only the impaired physician but the doctor's colleagues and hospital.

"The best advice to a physician who suspects a colleague is impaired is, 'Don't ignore the problem,'" says James C. Leonard, M.D., chairman of the Illinois State Medical Society's Physician Assistance Committee. The committee monitors the Society's Physician Assistance Program.

"Nobody does an impaired physician a favor by hesitating to get involved or by protecting that individual. That only delays the doctor's own recognition and acceptance of the problem and increases the chances a patient could be harmed. The ISMS Physician Assistance Program stands ready to offer guidance and to actively intervene on request."

Dr. Leonard and the Physician Assistance Committee offer the following suggestions to physicians who suspect that a colleague may have an addiction problem or a mental or physical illness producing impairment:

- Note any significant behavioral changes in personal and professional conduct. All of the changes described in the three cases above are indicative of impairment.

- If you suspect impairment, quietly gather information. Write down specific observations with dates. For example, "On Feb. 15, I was in the emergency room and I smelled alcohol on Dr. X's breath. On March 10 in the office, a patient complained to the staff that Dr. X made an inappropriate sexual advance. On May 11, Dr. X failed to cover my patients as previously arranged."

- With whom you discuss the potential problem depends on the circumstances. In a large clinic, designated staff to whom such reports are made and established mechanisms to address them may exist. In a two-person practice, the physician who suspects a problem may consider conferring with the hospital department chairman.

- A physician may call the Physician Assistance Program to report incidents indicative of impairment and to obtain guidance. Anonymity can be preserved if desired. The Physician Assistance Program may have

received other reports about the doctor in question, or can quietly gather information to document impairment.

- You may wish to talk to the impaired physician's spouse about the problem. Or, if a physician is a close friend, you might broach the subject with him or her. Physician Assistance Program experts suggest saying, "I am concerned about you because I have seen (a particular kind of behavior). This worries me. Is there something I can help with or something you would like to talk about?" This gentle approach sometimes is effective.

- A confrontation by trained individuals may be necessary to overcome the physician's denial of a problem and start the rehabilitation process. The Physician Assistance Program has trained physicians to respond to intervention requests and work with colleagues, spouses and other involved individuals.

- There must be a "bottom line" to a confrontation. The impairment must be thoroughly documented and the physician must understand that his or her license is in jeopardy or that the hospital will suspend or withdraw privileges unless the doctor seeks immediate treatment. Voluntarily agreeing to seek such treatment does not require a report to licensing or disciplinary authorities, nor is this action reportable to the National Practitioner Data Bank. Malpractice insurers, however, may require the physician to report impairment or treatment of impairment as a condition of coverage.

The program is not a "whistle-blower," Dr. Leonard says. "We don't turn in people to disciplinary and licensing authorities. We are advocates for the physician."

Getting the impaired physician to accept that a problem exists is the

program's main purpose. The physician then must consent to undergo physical or psychiatric assessments and enter appropriate treatment, Dr. Leonard says. When the treatment is completed, the program staff helps the physician return successfully to practice.

"We work with and monitor the physician for two to five years," Dr. Leonard says, "and we help create a paper trail that will document that he or she remains free of the addiction or other problem."

"If you know a physician has a problem and you choose to ignore it, you could face related liability yourself – as a colleague in the practice, as a member of a corporate practice or even as a referring physician," Dr. Leonard adds. "Although it hasn't been tested in court, a physician's referral to an impaired physician in the face of knowledge that an impairment exists could create liability."

State laws protect physicians who perform peer review or try to help impaired colleagues with their problems, Dr. Leonard says, unless these efforts are malicious or designed to help expand a competing physician's practice.

For more information about the Physician Assistance Program, contact ISMS at (312) 782-1654 or (800) 782-ISMS and ask for the Physician Assistance Program. ▲

Carol Brierly Golin is publisher of Medical Liability Monitor.

## Physician HELpline

A 24-hour Physician HELpline is available to link impaired physicians and their families with helpful resources. Contact the ISMS Physician HELpline at (312) 580-2499.

## Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602



**Q.** I am a recovering physician now in an aftercare program after completing treatment for an impairment. How does this affect my malpractice insurance?

**A.** The Illinois State Medical Inter-Insurance Exchange is committed to supporting impaired physicians, as is evidenced by the Exchange's support of the Illinois State Medical Society's Physician Assistance Program. So long as the Exchange receives assurances that the impaired physician is participating in a recovery program on a continuous basis, coverage will not be withdrawn. The Exchange must, however, have complete knowledge if it is to handle claims that may arise during a period of impairment. Therefore, unless the Exchange has received written notice of the impairment, it must exclude coverage for these claims. The reporting of impairment is requested on the Exchange application. In addition, physicians who, during their policy period, incur an illness or physical or mental impairment – including substance abuse – that impairs or potentially could impair

their ability to practice medicine, must notify the Exchange in writing.

**Q.** I would like to raise my liability limits. What do I need to do?

**A.** To increase your limits, you need to submit a written request authorizing us to do so. There are two factors that will affect the processing of your request. First, if this is a voluntary change, your request will be honored six months from the date we receive it. Second, if your request is an involuntary change (i.e., hospital requirements, practice relationship or an HMO requirement), we can waive the six-month waiting period and act on your request as needed. The appropriate policy documentation will be issued reflecting the change when we receive full payment of your premium. ▲



# Service to student athletes earns six Illinois MDs 1992 'Outstanding Team Physician' awards

by Kathy Meyer

FOR THE 10TH consecutive year, the Illinois State Medical Society honored six Illinois physicians for their contributions to young athletes.

ISMS First Vice President Arthur R. Traugott, M.D., presented three of this year's "Outstanding Team Physicians" – Thomas P. Driscoll, M.D., of Orland Park; Herbert F. Iknayan, M.D., of Robinson; and William F. Zwilling, M.D., of Barrington – with award plaques and bright red "team" jackets during opening

ceremonies of the Illinois High School Association Class AA Basketball Tournament. The March 19 presentation occurred before a crowd of about 2,500 at Assembly Hall on the University of Illinois at Urbana-Champaign campus. The remaining winners – Igor L. Dubravec, M.D., of Herscher; James L. Foresman, M.D., of Princeton; and Vaino Raag, M.D., of Addison – were unable to attend the event.

The team physician award program was instituted by the ISMS Sports Medicine Committee to recognize ISMS member physicians who

assist Illinois high schools with their sports programs.

"This year, the Sports Medicine Committee received 40 nominations from high schools and county medical societies throughout the state. While the competition was tough, the committee found six physicians who exhibit the qualities characteristic of an 'Outstanding Team Physician,'" said H. Bates Noble, M.D., chairman of the ISMS Sports Medicine Committee.

According to Dr. Noble, those qualities include providing more than 10 years of service to student

athletes; educating coaches, trainers, parents and athletes about the importance of prevention and treatment of sports-related injuries; contributing to the communities beyond the athletic field; and promoting or doing sports medicine research.

Dr. Driscoll, a pediatrician, was named "Outstanding Team Physician" for his 20 years' service to the entire sports program at Chicago's Leo High School. "Dr. Driscoll has been an inspiration to not only our present and past athletes, but also to our faculty and fans," wrote Brother Patrick D. McCormack, the school's principal, in nominating him for the award. Dr. Driscoll's contributions to the school have extended well beyond the playing field. He served as a past member of the Board of Directors and is past president and vice president of the Leo High School Foundation.

Dr. Dubravec, a retired family physician, served the Herscher High School football team between 1965 and 1991. "Dr. Dubravec has been a great asset to our small community and school by repeatedly volunteering his services over the years to our athletes," wrote Marlo Zehr, Herscher High School athletic director. Clifford West, school principal, praised Dr. Dubravec's deep concern for the athletes. "Whenever he is called upon, he responds immediately and remains with the injured player until the player is not only past the emergency physically, but emotionally, as well," he wrote.

In being named "Outstanding Team Physician," Dr. Foresman, a general practitioner from Princeton in Bureau County, was commended for his 27 years of service to the Princeton High School football and basketball teams. "The countless hours he has devoted to athletes illustrate the unselfishness of his character," wrote Carl Cherrie, school superintendent. Dr. Foresman was cited for taking time to cover not only home games, but for traveling to away games. On many occasions, Cherrie wrote, Dr. Foresman has been the only physician present and "the first person on the field or floor to treat injured athletes on both teams."

"Dr. Herbert F. Iknayan has given his time and efforts for a great number of years," wrote Rex Davis, Robinson High School athletic director. A general surgeon in the downstate community, Dr. Iknayan has served 20 years as the team physician for the football team. "Our student athletes all recognize him as a strong supporter of [the team]," wrote Davis.

Before retiring last year, Dr. Raag, a family physician, was team physician for the Addison Trail High School football squad on an alternating basis since 1965. "[Dr. Raag's] obvious concern for the welfare of our athletes is very gratifying to all who observe it," wrote James Mortimer, the school's athletic director. In the absence of a school athletic trainer, Dr. Raag helped prepare athletes for competition in addition to making decisions regarding athletic injuries.

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Dr. Zwilling, an orthopedic surgeon, has been a team physician for 27 years, serving four northwest suburban Chicago high schools in Barrington, Elk Grove Village, Forest View and Rolling Meadows. Nominators said his style illustrates a strong commitment to student athletes. "He acts not only as a doctor but as a friend and counselor, so as to treat the whole athlete," wrote Kenneth A. Stiff, athletic trainer at Rolling Meadows.

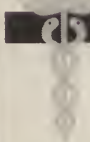
This dedication was evident at all the schools Dr. Zwilling serves. At Barrington High School, "Not only is he in attendance at our games, but he gives of himself every Friday afternoon at school to check progress and problems of athletes from all sports," wrote Robert Carpenter, athletic director. ▲



Frank Matheu, M.D., (left) presents James L. Foresman, M.D., of Princeton, with the Outstanding Team Physician Award at the Bureau County Country Club. Dr. Foresman and two other physicians who could not attend the ceremony in Champaign, were given their awards in separate ceremonies.



Above: Arthur R. Traugott, M.D., of Urbana, (second from left) presented (from left) William F. Zwilling, M.D., of Barrington; Thomas P. Driscoll, M.D., of Orland Park; and Herbert F. Iknayan, M.D., of Robinson, with their awards at the University of Illinois at Urbana-Champaign's Assembly Hall during the IHSA Basketball Tournament March 19.

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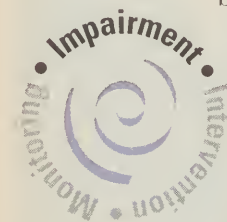
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# Key warning signs may signal impairment

by Rachel Brown



MISSED appointments, mood swings and increased irritability may just be signs of a bad day for many physicians. But when

these behavioral changes are consistent and progressive, the problems may signal something as serious as impairment.

In Illinois, anesthesiologists, emergency room physicians, psychiatrists and surgical subspecialists are at a higher risk of chemical dependency, according to the Illinois State Medical Society Physician Assistance Committee.

Dan Angres, M.D., a committee consultant and medical and executive director of the Parkside/Woodridge treatment program, says that the abuse of drugs and alcohol is the most common type of impairment among physicians.

Other types of impairment include psychiatric disorders, combined chemical dependence and psychiatric disorders (also known as dual diagnosis), physical disabilities, sexual misconduct and aging problems, he says.

"There are typically six areas of a physician's life most affected by impairment: employment, office, hospital, physical status, family and community," according to Fred Z. White, M.D., a committee consultant.

Dr. White told *Illinois Medicine* of several warning signals that occur in both the physician's professional and private lives. For example, physicians with a chemical dependency often fall asleep at the office or at home for no apparent reason.

Generally speaking, "The first place [symptoms] show up is in the home," says Kathy Angres, M.S., R.N., Illinois State Medical Society

Auxiliary representative to the committee and part-time family consultant at Parkside/Woodridge.

"Spouses should become concerned if the physician's personal hygiene deteriorates, if he or she experiences marked weight loss, has a reduced attention span or becomes increasingly irritable," says Dr. White.

Sexual problems such as extramarital affairs, and problems with sexuality and intimacy are also common with impaired physicians, Angres explains. In addition, she says, it is a common practice for impaired physicians to isolate themselves from family, friends, colleagues and community activities.

She compared this isolation to peeling an onion. "[The physician] peels away the outer layers of the social strata until all that is left is the spouse and [the physician]." Angres, who is married to Dr. Angres, is co-author with her husband and an Atlanta-based physician of a book about physician impairment.

*Because physicians have devoted much time and energy to their careers, the workplace is usually the last place impairment becomes visible.*

Because physicians have devoted much time and energy to their careers, and have a desire to "preserve their professional stature above everything else," the workplace is usually the last place that impairment becomes visible, notes Dr. Angres.

Impairment in the workplace generally occurs in a significant progres-

## Risk factors for possible impairment

- Consistent mood swings; hostile, unreasonable behavior;
- Isolating oneself from family, friends and co-workers;
- Missed appointments, unexplained absences;
- Decreasing quality of performance;
- Evidence of impairment (e.g. alcohol on breath, excessive ordering of supplies of drugs);
- Deterioration of personal hygiene; marked weight loss;
- Forgetfulness; reduced attention span;
- Numerous job changes in past five years

sion, he says. Symptoms begin with consistent mood swings, obvious changes in patient care, missed appointments, and an increasing number of absences. Eventually, actual evidence of impairment, such as excessive ordering of drugs or the smell of alcohol on the breath, becomes apparent.

"The employment history of impaired physicians can also be a clue to possible chemical dependency or psychological problems," according to Dr. White. Numerous job changes and relocations, unexplained intervals between jobs and chronic late payment of malpractice premiums or licensure fees can all be indicators of impairment, he says.

### Denial complicates matters

Unfortunately, "massive denial" on the part of impaired physicians does not allow them to recognize or admit their problem and renders them incapable of helping themselves, Angres says. Even with years of medical education and training, "Physicians believe that [they] can take it and [they] won't get addicted," she explains.

Dr. White adds that family members are often slow to respond to warning signs because they have "put the physician on a pedestal and want to keep [him or her] there."

"Unfortunately, most spouses are

in denial as well and make excuses [for their spouse]," Angres agrees. These include blaming obvious changes in behavior on the physician's long hours, busy schedule and job-related stress.

Colleagues and co-workers may also be reluctant to act because they want to be absolutely sure of a physician's impairment before intervening. Dr. White points out that although a physician's job is constantly filled with uncertainty, "this is one uncertainty [colleagues of an impaired physician] just can't deal with."

Because of an increasing awareness of physician impairment, the formation of advocacy committees and the strong success of treatment programs, physicians need not worry that impairment will spell the end of hard-earned careers, Dr. Angres stresses. More than 80 percent of physicians who enter treatment programs today are able to re-enter the profession, he notes.

"There is more consciousness of the problem today," he concludes. "And there is a tremendous amount of support for rehab and re-entry of impaired physicians." ▲

## One physician's story

### 'I've got to do something this time to get well'

Many physicians have been helped by the Illinois State Medical Society's Physician Assistance Program, with a very high success rate among those who have been monitored. The following is one recovering physician's story, as told to *Illinois Medicine*.

I don't mind the monitoring. In fact, my wife is glad it's there, because whether I have a good day or a bad day, she always knows those urine tests are there and that the ISMS program is watching things. She no longer has to worry about me. I think the monitoring chafes some people. They resent it and feel they are not trusted. They say monitoring for a short time is OK, but not longer. Their attitude is, "Doesn't anybody trust me?" Of course nobody trusts you. They trust you to practice good medicine. They trust that you love your family and that you love your work. But they don't trust you to be honest about drugs or alcohol. That's just the na-

ture of the disease. We can't be very honest about it.

I had been previously treated and had done quite well for eight years. I was addicted to amphetamines and Valium-like drugs. I would use one to wake up with, one to work with and one to sleep with. But I didn't do the things I should have done, like attend Alcoholics Anonymous meetings or have a sponsor that I was talking to. At the end of eight years, I did what all addicted folks do if they don't have a recovery support system - I relapsed.

My wife noticed my erratic behavior and found a packing list for wholesale drugs I had ordered. I was called down to a room in the hospital and there was my wife, two physician friends, my department chairman and a priest. It dawned on me what it was about. My department chairman said, "There is a job for you here and we think highly of you. You're obviously a bright person, but you need to get help. We can't

go on letting you be a danger to yourself, your family and your patients. You cannot continue the way you are. We love you. We have a bag packed for you and a ride, and you will be leaving in 20 minutes for treatment." Those of us in treatment call this the "loving S.W.A.T. team."

What do you say? "No thanks?" You know full well they have talked to the hospital administration. Your wife is there and all the bases are covered. By the time I got to the treatment center, I was a very willing participant. I made real good use of my previous treatment and relapse. I said, "I'm getting too old and I love my kids too much and I like my work too much to ever do this again. I've got to do something this time to get well. I just cannot continue."

When I was out of treatment for five months, I went to see the ISMS program case manager. I was very fearful. I had heard that they're always checking on you. I think getting into treatment and getting on

the program is 90 percent of the battle. For the longest time I gave urine samples three times a week. At any given time of the day or night, they would call me. It's on my record if any one wants to check or has questions. Now, I give urine samples twice a month.

*"The time to worry about what people think is when they all know you're sick, not when they know you're getting better."*

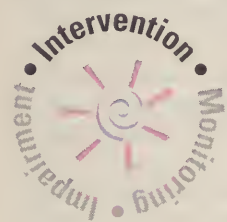
I go to AA meetings four or five times a week. I attend a couple of physician-only groups, but I like my other groups. I attend some with really salty people who have been clean and sober for 20 to 30 years.

I don't see drug reps anymore. They used to leave samples that I would take. I never touch the narcotics keys. I work slightly fewer



# Intervention: Confronting the impaired physician in a caring, non-judgmental way

by Tamara Strom



A PHYSICIAN sits nervously – and defensively – on a chair in his department chief's office. He is surrounded by family members, friends and colleagues. He does not understand why he's been called to this meeting, but he's sure they're dead wrong about what they're saying. He doesn't have a drinking problem.

But one by one – his wife, his children, his nurse, his business manager, his partner and department chief at the hospital where he is a top admitter – all recount documented incidents of his erratic behavior during the past two years. They list complaints from patients. His patient records, once impeccable, are now confused and hard to read. He often misses appointments and consistently asks his wife to make excuses for him.

Most of these people have already tried confronting the doctor individually about their perception that he has a drinking problem. Rebuffing all of them, he would admit having a few drinks now and then, but he would invariably add, "That certainly doesn't mean I have a problem." But the situation is now out of control, these concerned family members and colleagues contend, and they have sought help

from the Illinois State Medical Society's Physician Assistance Program. They have called this meeting – an intervention – to help the physician to acknowledge his impairment and seek treatment.

"Intervention is the process of motivating people to get some help before they actually feel the need to help themselves or before they're willing to take those steps," says Martin Doot, M.D., vice president of

way. You're blocking someone from getting away with their dependency. The intervenors must keep this in mind during the difficult intervention meeting."

Dr. White stresses that the intervention must be carried out in a "loving, caring, helping" manner. "The goal is not to threaten the doctor or push someone's face in the mud, but to speak softly and carry a big stick – the stick being the consequences of the doctor not facing his problem and getting help."

While these interventions are sometimes volatile and emotional, they are well-rehearsed and the participants well-prepared to carry out their individual roles. Dr. Doot says the meetings are structured around basic principles of intervention.

The most important people in the physician's life – those people he or she loves and respects – should be involved, Dr. Doot says. These are the individuals who are likely to have the most compelling information necessary to confront doctors about their impairment. Dr. White adds that it is important that no one on the intervention team be a competitor of the physician, because the doctor could then rationalize that the process is financially motivated. "Intervenors should be those people who are interested in having the physician get well," he notes.

The incidents must be collected and written down by these important people, Dr. Doot says. "The data must be specific with dates and times, related to the doctor's substance abuse and experienced by the person collecting it," he says, adding that circumstantial, secondhand information probably won't be detailed enough to convince a physician that he or she has a problem. That doesn't mean, however, that colleagues should disregard recurring stories from the hospital grapevine.

During the intervention, this information is presented to the doctor by the person who experienced the incident, as long as that person is not too angry to participate in a meaningful way, Dr. Doot says. "All of the people involved relate how they feel about what has been happening in a caring, non-judgmental way," he notes. "They explain, 'This is what happened, this is what I saw, and this is how it makes me feel.'"

The intervenors also offer the physician choices for treatment. "People feel desperately out of control, so to offer them a choice is important," Dr. Doot says. "But the choices must be appropriate. 'Which help do you want to go for?' not, 'Do you want to go or not?'"

Because doctors often will resist recommendations to enter treat-

ment, the team must be prepared for a refusal. Specific consequences for their refusal to seek help must be given, Dr. Doot says. "Don't use the same old threats that you've never followed up on before," he notes. A spouse could say she won't cover for her husband anymore, taking away the soft cushion for his dependency, or a partner might begin splitting the practice. "Discipline and help do not have to be opposite ends of the spectrum," he adds.

Although physicians usually don't leave an intervention and immediately enter treatment admitting they have a problem, their prognosis for recovery is substantially better than the general population if their family and friends intervene before the doctor loses everything, he says.

"While people are still in the work environment, their prognosis is excellent," he says. "If they receive good treatment, monitoring for two years and participate in self-help groups, their prognosis is 85 percent to 90 percent. We have the opportunity, through the medical society and the disciplinary boards, to motivate our physicians to do all three. We can expect them to do all three, and if we do, we can expect an excellent outcome." ▲

## Treatment programs address unique impairment issues

by Tamara Strom

While the intervention process may break through an impaired physician's denial, many physicians still deny their impairment even after an intervention. It is crucial for intervention team members to give the doctor succinct treatment options. Intervenors may offer physicians an evaluation to assure a problem exists or suggest participation in an Illinois State Medical Society Physician Assistance Committee-approved treatment program.

"The committee has its own criteria on how to judge a good treatment program," said Martin Doot, M.D., vice president of medical services at Parkside Medical Services Corp. "It must have experience working with physicians and other professionals. It's difficult sometimes for physicians to identify with other patients in treatment if there aren't other professionals."

The Physician Assistance Committee requires the programs to:

- Address the special issues and concerns of impaired physicians who intend to re-enter practice after treatment.
- Have experience with the unique drugs physicians use.
- Acknowledge and address the common self-prescribing habits of physicians.
- Be familiar with the institutions of a physician's life, such as hospitals, clinics, etc.; a doctor's family life; and the range of physicians' clinical practices to assure a smooth re-entry and prevent a recurrence.
- The staff must be comfortable confronting physicians and must not be intimidated by a doctor's strong personality. ▲



Illustration: Katherine Streeter

medical services at Parkside Medical Services Corp., who trains physician intervenors for the ISMS program.

"Physicians are often deep in denial when an intervention is called," says Fred Z. White, M.D., a consultant to the ISMS Physician Assistance Committee. "The intervenors must close off all the exits for the physician and must really box him in. This is done in an un confrontational

rate from the state licensing board. It was not clear to me before I was on the program.

There are channels for [seeking treatment] without ruining your career. That's everybody's fear: "If I come forward, I'll never practice medicine again." We cannot come to the logical conclusion that it would be better for us to get treatment. We keep telling ourselves, "Under no circumstances will I go. I'll do anything before I go into a treatment program and, God, I hope I don't get found out."

The state does know about me. I made a special appearance before them when I got my Illinois license in the early 1980s. Then, in 1989, the state licensing board asked a question for the first time about impairment. I had some decisions to make and I checked "yes" and was open to full examination by the licensing board.

For me, treatment was a tiny beginning. I didn't think so when I was there. I thought it was an eternity. The real work starts in getting your track record together, the passage of time and learning to live without drugs. ▲

nights than the other physicians in our group and work more weekend days. When I work nights, I have trouble sleeping during the day. I have to miss noon conferences twice a week to go to AA meetings.

For me, going public was real important and not a choice. Our chief had to tell 20 residents and 35 nurses. People are rooting for you from the beginning. It's amazing how supportive people are once they know the truth and that you are trying to get it taken care of. I was fearful about coming back after being in treatment for four months, but they were very supportive. It's not so terrible if people know. The time to worry about what people think is when they all know you're sick, not when they know you're getting better. I can't abuse their trust. I can't say, "They're being so nice, I'll just take a couple of pills."

If I don't make it this time, I'm just going to turn in my medical license. For me, it's kind of all or nothing. I would look for some other work before I would put everybody through this again.

It took me a long time to figure out that the ISMS program is sepa-



# Monitoring helps recovering physicians stay well

by Kevin O'Brien



IT DOESN'T just go away.

Most physicians consenting to any type of treatment for impairment are

looking to put the past behind them, says James C. Leonard, M.D., chairman of the Illinois State Medical Society's Physician Assistance Committee. "They're of the mind-set, 'OK, I've dealt with this. Let's put things behind us and go on.'"

But a situation has been created where that simply is not possible, says Dr. Leonard. The recovering physician must be monitored to en-

sure he or she continues to recover. And, more often than not, monitoring is not an easy experience.

"Their toes are going to be stepped on," Dr. Leonard continues. "I promise every recovering physician that at one point or another, a question of their sobriety will come up. They'll be having an off day, and the first question on everybody's mind will be, 'Is he using chemicals again?'"

Everybody is entitled to an off day, which is why a formal monitoring program is necessary. Not only does it reassure a physician's family and colleagues that he or she is making it, it protects the physician from an unfair accusation and protects the patient.

"I see monitoring as the behavioral part of the treatment," says Amin N. Daghestani, M.D., a committee member and a treating physician. "In a way, it is saying to the physician that, 'We care about you enough to make sure that all these monitoring mechanisms are in place.'"

Implementing those mechanisms begins with the contract. Every recovering physician in the ISMS Physician Assistance Program must sign a monitoring or "aftercare" agreement. The agreement is between the recovering physician and the program, and may also include other parties, such as the hospital where the physician is on staff, or his or her group practice. Provisions vary with the type of impairment and information required, but typically include certain components.

First, the agreements mandate that the physician either completes or continues prescribed treatment. "Not all impairments require an inpatient program," notes Dr. Daghestani, although the majority of substance abuse cases will begin with some sort of inpatient treatment.

Attendance at self-help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, other support groups) is typically required and monitored, as is random, witnessed urine testing, in the case of substance abuse impairment.

"One of the most important things that I stress to people coming out of treatment is the need for consistency, the need for a facilitator who is keeping records," says Dr. Leonard. "That this physician has been randomly [urine] tested on multiple occasions, that they've kept their appointments, that they're doing this and that to stay healthy."

The monitoring agreements can last from three to five years, although five is becoming the norm. "We're finding that the longer periods of time are really important in terms of building trust and building long-term sobriety," says Dr. Leonard.

One of the reasons it takes so long is that many physicians – even those who through intervention have acknowledged that they need and want help – have trouble asking for it. A sense of powerlessness and guilt and shame is associated with their impairment, says Martin Doot, M.D., vice president of medical services at Parkside Medical Services Corp.

*"Part of the treatment is to [teach physicians] how to ask for help, that it's OK to ask for help, and that we all may need help."*

"They can get themselves into deep trouble and have difficulty grasping some of the simplest recovery principles – like 'Ask for help,' or 'Don't do it yourself,' or 'Keep it simple, don't make it so complicated,'" he says.

"Part of the reason they got into trouble in the first place is that they have difficulty asking for help, or they have difficulty recognizing the need for help," agrees Dr. Daghestani. "And so part of the treatment is to address that. [We teach them] how to ask for help, that it's OK to ask for help, and that we all may need help."

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor, Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

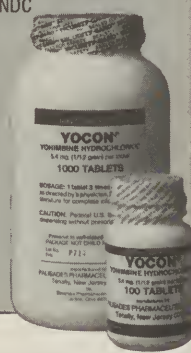
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## Resolutions

(continued from page 1)

Trustees to serve three-year terms; the number of consecutive terms is limited to three, but there is no lifetime limitation.

The resolution responds to a 1991 House of Delegates move to limit officer and trustee terms. While the House defeated the resolution, ISMS Board of Trustees Chairman George T. Wilkins Jr., M.D., pledged that the Board would study the issue and report back to the House in 1992. One other resolution to be considered this year asks that trustees be limited to three terms of three years' duration each.

Malpractice reform is highlighted in two resolutions. One proposes conducting a study of a "no-fault" malpractice system "as an appropriate reform of the legal process." The other resolution calls for provisions for caps on non-economic damages in malpractice cases to be "an integral and necessary part of any national public health care policy reform" and directs the introduction of state and federal legislation to that effect. The Cook County delegation has introduced a resolution outlining the role and obligations of physicians who appear as expert witnesses in malpractice cases.

Three resolutions call for comprehensive public education campaigns explaining the reasons for escalating health care costs and analyzing various proposals for health care re-

form. Another resolution seeks to address the health care access problem by urging greater physician involvement in access program development, while others ask the House to endorse specific proposals, including "pay or play," single-payer universal health insurance legislation and the AMA's Health Access America program.

## Peer review and utilization review

Peer review and utilization review will once again be major topics as delegates debate several resolutions impacting these issues. One resolution asks the Society to urge the U.S. Health Care Finance Administration to open bidding on a new Illinois peer review contract. Another asks for legislation regulating utilization management organizations. Still another would require PROs to provide that physicians who receive minimal adverse reviews have "their commendable behavior reinforced with a letter of quality confirmation from the PRO."

A number of social issues – several resurfacing from past annual meetings – are reflected in resolutions addressing family violence; helmets for motorcyclists; prohibiting smoking in enclosed stadiums; firearm safety training and handgun control; regulation of tattoo parlors and electrolysis; taxes on tobacco products and government subsidy of tobacco farmers; the legal definition of death and physician participation in criminal executions. ▲



Dr. Doot says that the choice of the treating physician is a crucial factor in a recovering physician's success. "I think a key in this is having people who understand physicians and their unique problems," he says. "You have to understand the unique re-entry issues that doctors have. ... [So] you need to do a whole lot of relapse prevention work before you test that reentry."

The support of a recovering physician's family and colleagues is also a critical element in his or her recovery. "Be supportive," says Dr. Daghestani, "And be available. Do not reject the physician."

But even when all the critical elements are in place, the nature of impairment means that some physicians will have a relapse. When it happens, the Physician Assistance Program must treat it seriously.

"We sit down with the physician and tell him or her that they've violated the contract and that we must make a decision about where we go from here," says Dr. Leonard. If there are other parties to the contract, then they too must be informed of the violation and, "Often they will have something to say about what happens next. [Options can range] all the way from, 'OK, let's pick up from here' to loss of licensure."

Dr. Leonard stresses, however, that, "The program typically does not make that decision. We are physician advocates. What we try to do is work with the 'powers that be' in a physician's life in terms of what is acceptable. ... [But] we do not decide the punitive measures. That's not our role."

The good news is that the recovery

rate among impaired physicians is extremely high. One of the reasons is that a physician's identity is so often tied up in his or her vocation. Consequently, the importance "of the license and the job is to them a tremendous motivator," says Dr. Doot. "The key is using that motivation for a long enough time to get through the barriers [and ensure] that physicians get the treatment they need ... over the long haul, not just for brief periods of time."

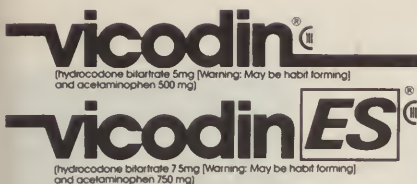
And, when that happens, Dr. Daghestani says, it is very gratifying. "It is very rewarding to me to be able to help fellow physicians," he says. "To see a physician back at work, getting back as a contributing and useful member of society, is quite rewarding." ▲



## ISMS Physician HELpline

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The Physician HELpline is a confidential, physician-directed advocacy service linking mentally or physically impaired physicians and their families with helpful resources. Call the 24-hour Physician HELpline when someone you know needs help. ▲



**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

#### WARNINGS:

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

#### PRECAUTIONS:

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytic agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

#### Usage in Pregnancy:

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Urteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

#### DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

#### OVERDOSAGE:

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

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COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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# IDPR offers alternative approach to impairment issues

by Anna Brown

DETERMINING IF PHYSICIANS are "able to practice with reasonable skill and safety" is the goal of the Illinois Department of Professional Regulation and its medical coordinator, Warren H. Staley, M.D., when facing physician impairment issues. Dr. Staley explained the department's position on impairment issues to the Illinois State Medical Society's Physician Assistance Committee on Feb. 28.

The Medical Practice Act of 1987

allows IDPR to consider an alternative to disciplinary sanctions for impaired physicians, Dr. Staley said. The department's "agreement of care, counseling and treatment" allows physicians who may be impaired, but who have not otherwise violated the Medical Practice Act, to work with IDPR as long as they are being monitored and are in recovery.

"A physician may be impaired in some way and still practice medicine with reasonable skill and safety," said Dr. Staley. The department's moni-

toring of such physicians provides assurances that the public welfare is being safeguarded without unduly penalizing the recovering physician.

Physician participation in the department's agreement of care, counseling and treatment for impaired physicians is kept confidential, said Dr. Staley. The agreement is not reportable as a disciplinary action and provides a means for physicians to assist in the monitoring of their own recovery.

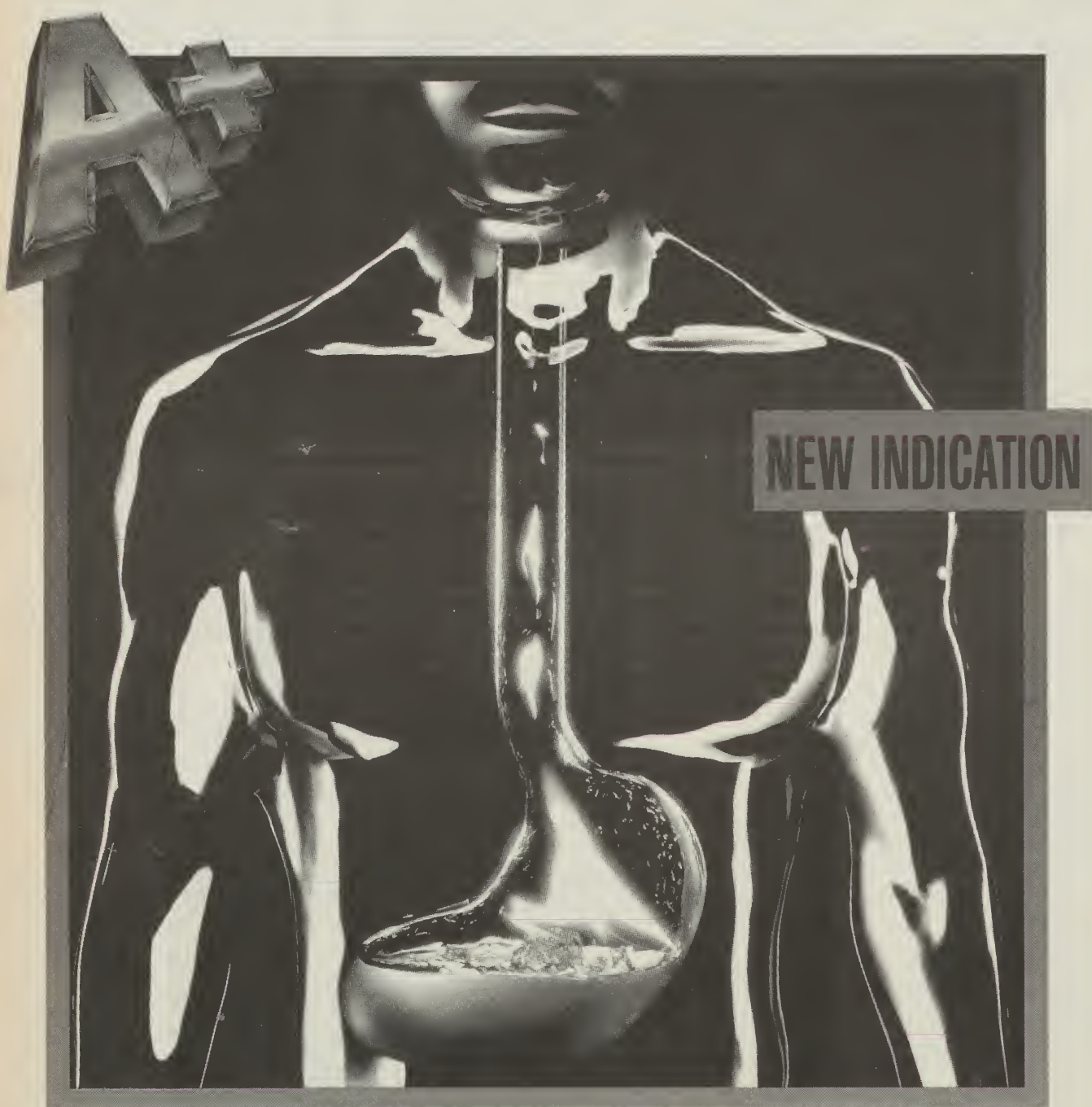
## Route to recovery

The agreement is an option in cases where a physician volunteers to be monitored by the department, thereby acknowledging his or her impairment. In the majority of cases, the medical coordinator may interview the physician to discuss the impair-

*"If a physician voluntarily seeks help, and does not have any restrictions of practice, he or she may not be disciplined."*

ment, and to outline the terms of the agreement.

"If a physician voluntarily seeks help, and does not have any restrictions of practice, he or she may not be disciplined," Dr. Staley said. Some impairments, such as an age impairment, are not amenable to the agreement. However, in such cases, a



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**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

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physician may be asked to voluntarily surrender his or her license.

The medical coordinator, on behalf of the Medical Licensing Board or the Medical Disciplinary Board, may suggest that the physician enter into the agreement if no violation of the Medical Practice Act has occurred. Before a physician enters into an agreement, its terms must be presented to the appropriate medical board in closed session. Since the time of the first agreements in June 1989, the board has not denied any agreement recommended by the medical coordinator, said Dr. Staley.

Once in the program, participants are monitored regularly by the department. Length of the program depends on the individual situation. Most terminate after three to five years; however, some members of

the Medical Disciplinary Board feel that impairments can be lifelong problems that require ongoing monitoring, said Dr. Staley.

#### Confidentiality assured

Unlike violations of the Medical Practice Act, which require disciplinary proceedings, participation in an agreement of care, counseling and treatment is not punitive, and therefore is not reported to the National Practitioner Data Bank.

If, however, the impaired physician does not follow the terms of the agreement, the department may take formal, punitive action that could include probation or suspension of the medical license. Once the department files a formal complaint against the physician, information pertaining to the case becomes part

of the public record, said Dr. Staley.

Agreements may be used for alcohol and drug abuse and mental impairments. IDPR allows impaired physicians to participate in any number of treatment programs while under an agreement, and physicians may be allowed to modify individual programs by petitioning the medical coordinator. Dr. Staley stressed that while a physician may participate in a variety of programs, including the ISMS Physician Assistance Program, it is the physician's responsibility, not the program's, to report his or her progress to the department. The department's position is that physicians must admit they have an impairment before entering into an agreement, he said. ▲



IDPR Medical Coordinator Warren H. Staley, M.D., addresses the Physician Assistance Committee on impairment issues.

## Members in the News

**Jack L. Gibbs, M.D.**, of Canton, received the 1991 Illinois Farm Bureau Distinguished Service Award, presented by the organization at its annual meeting in Chicago. Dr. Gibbs, who has practiced medicine in rural Illinois for nearly 40 years, has spent much of that time on the Medical Student Loan Fund Board, now known as the Rural Illinois Medical Student Assistance Program. Through this program, he has stressed to students the need for quality medical care in rural areas. In his role as a community leader, Dr. Gibbs was instrumental in establishing 911 and emergency medical services in Fulton County. He also developed a slide presentation and lecture on farm injuries that has been shown for more than 20 years to farm groups and high school and college agriculture classes. Dr. Gibbs received his medical degree from the University of Illinois College of Medicine at Chicago.

**Thomas R. Huberty, M.D.**, of Sugar Grove, was appointed to the Board of Directors of Mercy Center for Health Care Services in Aurora. Dr. Huberty, a graduate of the University of Illinois Abraham Lincoln School of Medicine, joined the Mercy medical staff in 1976.

**Charles J. Wright, M.D.**, of Rockford, was named medical director of the neurological intensive care unit of Saint Anthony Medical Center in Rockford. Dr. Wright earned his medical degree from

the University of Illinois College of Medicine at Rockford. As medical director, Dr. Wright will oversee the quality of care provided in the unit, and will coordinate continuing education activities for physicians and nurses. **Paul M. Christensen, M.D.**, of Rockford, was named president of the St. Anthony medical staff for 1992. Other officers include **James W. Girardy, M.D.**, of Rockford, vice president; **Ralph R. Velazquez, M.D.**, of Rockford, secretary/treasurer; **Christopher A. Green, M.D.**, of Belvidere, chief of staff; and **Paul A. Maxwell Jr., M.D.**, of Rockford, director of medical education. ▲



Charles J. Wright, M.D.

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# Health care dollars 'well spent,' say mini-internship participants

by Kathy Meyer

INSTEAD OF complaining, Americans should be "bragging" about their health care system, said a participant in the mini-internship program sponsored by the Illinois State Medical Society and the ISMS Auxiliary.

"It's a popular thing to attack providers when you see costs go up as much as we have," said Gerald Stephens, president of RLI Corp., a Peoria-based insurance company that has seen health care costs rise 20 percent in the past five years. Stephens recently completed a mini-

internship with David M. Johnson, M.D., a Peoria internist. "But take a look at what we're actually buying," he continued, citing the lifesaving technology he witnessed that contributes to the cost of health care.

Stephens was one of 56 laypeople — including U.S. congressmen, state legislators, city mayors and local hospital officials — who during January and February participated in the mini-internship program. The program is designed to demonstrate "just what the day in the life of a physician is like, from patient exposure to paperwork to the phone calls," said John R. Krueger, M.D., a

Bloomington internist, who hosted an insurance company executive. Daniel E. Lanzotti, M.D., a Springfield family physician, said it was important to show his intern, State Rep. Karen Hasara (R-Springfield), "the frustrations of our present system, the difficulties of the working poor [and] the problems of small group practices."

The mini-internship program is co-sponsored by ISMS and the ISMS Auxiliary and coordinated through the county medical societies and auxiliaries. This year, nine county medical societies and auxiliaries participated in the mini-internship program, including Adams, Macon, McDonough, McLean, Peoria, Rock Island, Sangamon, St. Clair, and Tazewell counties. County medical societies in Lake, Winnebago and Champaign counties also sponsor

*"We all work hard, but until we see a physician working — the dedication, the commitment of time — it's hard to really appreciate what a physician's life is like."*

mini-internship programs.

Ray LaHood, U.S. Rep. Robert Michel's (R-Peoria) chief of staff, went into the program with the perception that "doctors work hard," he said. "That [perception] was borne out more dramatically after spending 10 to 11 hours with Dr. Gerstner." James B. Gerstner, M.D., is a Peoria hematologist.

LaHood's day started at 7 a.m. with hospital rounds, then moved on to Dr. Gerstner's office around 9:30 a.m. "He didn't take a coffee or lunch break. He finished seeing patients in his office at 6:30 p.m.," and then went back to the hospital for scheduled appointments and to see patients he had admitted during the day. "It was obvious that he wasn't going to get home until 8 p.m. or 9 p.m.," LaHood said. "I had no idea of the sacrifices these guys make."

Phil Hare, aide to U.S. Rep. Lane Evans (D-Rock Island), had a similar experience with Patrick C. Cunningham, M.D., a Rock Island internist. Following morning hospital rounds, the two saw patients at the Robert Young Center for Community Health before going to the doctor's office. "I was amazed at the number of patients he sees during the course of a day," Hare said. "I was amazed at how the doctor could keep all of his patients straight and could make all of them feel special."

"The pace was quick," Hare continued. "At the end of the day, my feet were burning." The only slowdown came when a few patients declined to let Hare observe their examination. During these times, Hare attended a nursing staff meeting and talked to the business staff about billing procedures and the problems they experience.

Roger Schluter, a reporter for the *Belleville News-Democrat*, observed the Southern Illinois University School of Medicine's Belleville Family Practice Residency Program headed by Gerald D. Suchomski, M.D., a family physician. And U.S. Rep. Thomas W. Ewing (R-Pontiac) spent his day with Bloomington general surgeon Richard C. Trefzger, M.D., standing "right next to his elbows" during surgery. All agreed that their experience gave them a newfound appreciation for physicians.

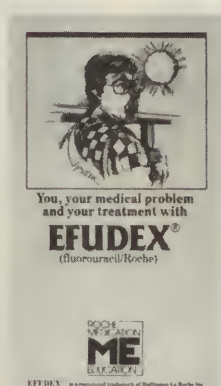
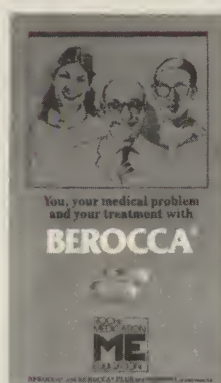
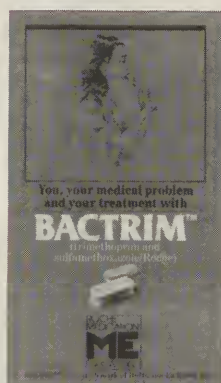
"There's always a sense of urgency in a doctor's day that we don't have in a regular business day," said Leonard Marshall, president and chief executive officer of Jefferson Bancorp Inc. in Peoria. Marshall, who also sits on the St. Francis Hospital Advisory Board, spent the day with Donald McElroy, M.D., a Peoria cardiologist. "We all work hard, but until we see a physician working — the dedication, the commitment of time — it's hard to really appreciate what a physician's life is like."

Until he went through the

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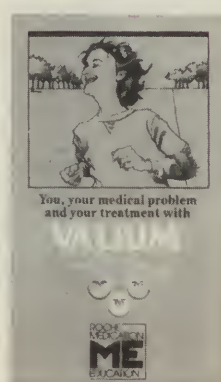
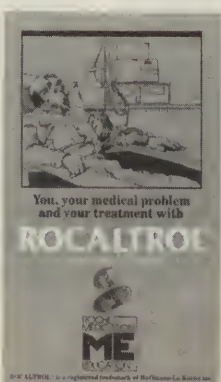
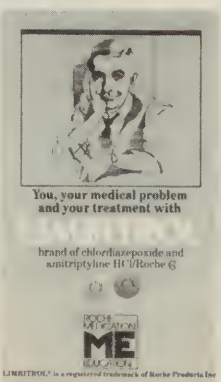
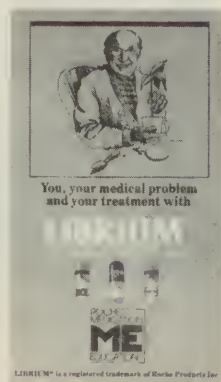
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Tazewell County Medical Society mini-internship program, State Rep. Thomas Homer (D-Canton) said, "I didn't realize to what extent [physicians] carry the burden of life and death" and the delicate manner in which they must deliver care. During a day spent with Michael L. Taylor, M.D., an internist in Pekin, Homer met several cardiac and cancer patients with grim prognoses. Dr. Taylor "didn't withhold any information" from his patients in discussing plans for treatment and the possible outcomes. "You could see he had a deep concern personally" for his patients. "He struggled with the situation, yet he was very decisive about medical treatment," Homer said.

To the patients' families, Homer said, Dr. Taylor's "presence was a great source of comfort, although there was little he could do. It meant so much to [them] that he was over-seeing treatment. One woman embraced him." This convinced Homer that, "A doctor does more than give advice, prescribe medicine and outline a health plan. People look to their doctor in times of a crisis for support."

State Rep. Duane N. Noland (R-Decatur) saw these attributes in Bruce Stiles, M.D., a Decatur family physician. "Sometimes he provides more than medical advice. He offers psychological advice and his friendship."

Most interns felt that this compassionate care needs to be preserved in the American health care system. David Kaehler, executive director of Peoria Area Labor Management, said the mini-internship program reconfirmed that there is something unique about the American health care system. "It's paramount that we don't do anything to destroy this quality. There's still that personal touch that exists and that's where quality care is."

Still others attributed the high quality of health care in the United States to the sophisticated, lifesaving technology available to physicians today. Donald Englekes, vice president, Country and Life Insurance Co., observed how physicians can examine human organs through the use of scopes, making it possible to detect the early stages of cancer when the chances for survival are the greatest. "I didn't realize these abilities were there," he said. "My, what this has done for medicine."

"I'm more confident today that our [health care] dollars, while they're increasing, are well spent," Stephens said, referring to the technology he observed during his internship. He pointed to magnetic resonance imaging, which "gives the medical community a lot more information than they ever had before." As a result of this technology, "The quality of life of our nation is better than it's ever been. We're apologizing for something we should be bragging about."

Yet, interns learned that all of this technology doesn't come without a price. After observing J. Anthony Dustman, M.D., a Bloomington orthopedic surgeon, perform an arthroscopy of the knee, State Sen.

## A look at some of 1992's interns ...



Above: Illinois' first lady Brenda Edgar (rear) looks on as Ann Pearson, M.D., of Springfield, treats a young patient, Trevor Johnson.



Above: Macomb Mayor Tom Carper gets firsthand experience with diagnostic equipment at the office of Macomb physician Dennis Samuelson, M.D.



Above: Karen Ruggless, R.N., and Brian Miller, M.D., (right) show Mike Daly, an administrative assistant to U.S. Rep. Richard Durbin, the patient records they maintain daily.



Above right: Cameron Olson, M.D., of Springfield, (left) shows Illinois Department of Public Aid Director Philip C. Bradley some of the daily paperwork a physician has to complete.



Above: Illinois Rep. Thomas J. Homer (D-Canton) looks on as Michael Taylor, M.D., of Pekin, (right) explains a patient's chart.

Below left: Sue Clark, R.N. and Sen. John Maitland Jr. (R-Bloomington) (both at left) watch as J. Anthony Dustman, M.D., (right) and assistants Beth Roseman, a surgical technician, and Mary Jane Schenkel, L.P.N., operate on a patient in Bloomington.

John W. Maitland Jr. (R-Bloomington) said, "When you pay for surgery, it doesn't go into Tony Dustman's pocket. You pay for the operation ... the expensive equipment and the additional cost of running an insurance office."

In fact, all interns had a better sense of where health care dollars are being spent after completing the mini-internship program. "A lot of the rising cost of health care," Hare explained, "is due to, first, the paperwork and, second, the tests involved."

*"I had no idea of the sacrifices [physicians] make."*

Hare said Dr. Cunningham convinced him that defensive medicine contributed a great deal to the cost of health care by sharing several examples with him. One that stuck in his mind was that of physicians ordering brain scans for tumors for patients complaining of headaches. The doctor told Hare that most people simply have a headache, but he added, "We don't want to order them, but it's mandatory." "I knew there was a lot [of overtesting],"

Hare said, "but I didn't realize just how much."

"I realized that the great expense involved in medical care is the person going through the paperwork, collating documents, signing reports and dispensing the paperwork," said John T. Dozier, executive vice president, Dozier Insurance Agency in Quincy. During his internship with Jerry Kruse, M.D., a Quincy family physician, Dozier reviewed billing procedures and the paperwork that's involved. "If this can be simplified, reduced or streamlined, it will help reduce costs."

As one of those who add to the voluminous amounts of paperwork a physician must go through, Englekes, whose company administers health insurance policies, said, "I have a better feel for some of the priorities they have to establish. Which is more important: Is it seeing patients, or completing the paperwork? I think it's seeing the patients." While he would not say if he could reduce the paperwork required of physicians, Englekes said, "I will have more empathy with the sometimes perceived lack of attention to paperwork. Now I understand why it takes a day or two longer than what we expect it to."

None of the interns blamed physician fees for the rising costs of health care. "I've paid plumbers

more per hour than what he's receiving," said Stephens, after learning what Dr. Johnson charged his patients. Instead, many sympathized with their plight.

Jay Vonachen, president of Vonachen Industries in Peoria and member of the St. Francis Hospital Advisory Board, had the opportunity to examine the accounting ledgers during his day with Leslie E. Johnson, M.D., a family physician. "For all he went through to get educated, and all he goes through to be a doctor, he doesn't get paid enough," he said.

While interns said the mini-internship program opened their eyes to the problems facing Illinois physicians, no one claimed to have a solution to the nation's health care crisis. "There's no simple answer to solving our national health care problems," said Glen Barton, trustee at Proctor Hospital in Peoria. Barton spent a day with John M. McLean, M.D., a Peoria neurologist. "But one thing I know for sure is that we can't reproduce a bureaucratic maze on top of what we already have."

Echoing Barton's feelings, Dozier said, "Government intervention tends to only complicate, stagnate the doctor's desire to cure his patient. These are intelligent physicians who are stifled" by the paperwork currently mandated by government bureaucracy. He believes a single-payer system "will ruin the medical profession" and "will result in less care in Illinois." ▲



# Physicians can hone quality control, proficiency testing skills

by Tamara Strom

EVERYONE KNOWS clinical laboratory regulation will get tougher in the coming months. But whether new federal rules or a version of the current Illinois law will be enforced is yet to be determined.

The Illinois Department of Public Health, the state agency responsible for lab regulation oversight, and other interested parties, including the Illinois State Medical Society, are analyzing the relationship between the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and the Illinois Clinical Lab Act. The only certainties at this time are that

some regulation will go into effect this fall and that the federal government is gearing up to begin collecting fees in May from all physician office labs to fund its regulatory efforts.

"CLIA is an important issue for practicing physicians," said IDPH Director John R. Lumpkin, M.D. "[The federal government] has developed a law that will significantly affect the cost of health care. [Gov. Jim Edgar] has made it clear that he doesn't believe in unnecessary and duplicative legislation. Our goal is to have a regulatory program that is manageable ... and to make sure the regulations maintain quality and have the least effect on the cost of medicine."

Despite the uncertainty, there are some concrete steps physicians who perform office lab tests can take to ease the transition into stepped-up regulation. The ISMS Committee on Blood Banking and Laboratory Services and the Council on Medical Services recommend that Illinois physicians who wish to continue office lab testing under CLIA learn the ins and outs of quality control and proficiency testing.

"We don't know the details of what the laboratory regulations will bring, but we do know the flavor," said Richard J. Sassetti, M.D., ISMS blood banking committee chairman. "If physicians buy into the concepts of proficiency testing and quality control they will be more prepared. If they can master these two areas, their major adaptive hurdles for lab regulation will be accomplished."

The average physician — who has no responsibility for lab operations other than the limited tests run in the medical office — is probably not fully apprised of all the things that can go wrong with a lab test, Dr. Sassetti said. "If they can get themselves attuned to proficiency testing and quality control — the most difficult issues cognitively — then the rest of compliance for them will probably just be following the regulations," he noted.

Dr. Sassetti said physicians should create procedure manuals for their labs to track quality concerns on a daily basis. He said physicians should maintain strict adherence to manufacturers' quality control instructions

for test use.

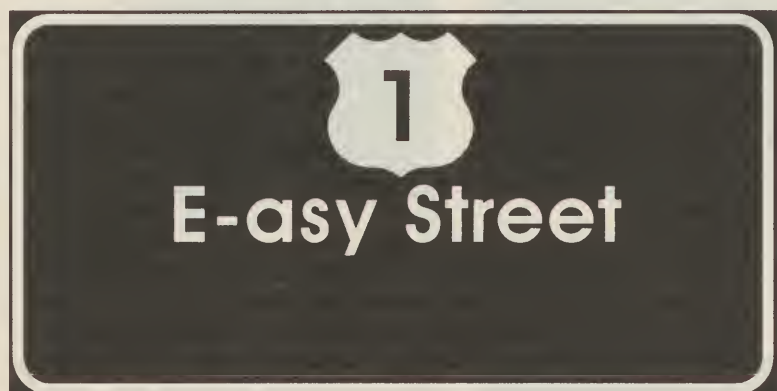
IDPH surveyors maintain that quality control is the "heart and soul" of the laboratory. The department stresses that physicians who perform limited numbers of tests must make the greatest strides in becoming proficient at quality control procedures. The only way for a physician to assure that his or her lab results are reliable is to run daily control tests on each test to be performed, according to the department.

Although the federal laws give physicians a grace period to begin proficiency testing, Dr. Sassetti recommends doctors start now. The outside check on lab test results is performed by an independent group such as the College of American Pathologists. Three to four times a year, the doctor receives several unknown samples to run through normal testing procedures. The physician then sends the results of those tests back to the testing agency and the results are graded.

"If a physician fails two proficiency checks in a row, or in some cases fails two out of three tests, he or she can no longer bill for that analyte until they can demonstrate proficiency on that test," Dr. Sassetti said. "So it behooves a doctor to really understand proficiency testing."

For more information about quality control and state-approved proficiency testing services, contact IDPH. Watch *Illinois Medicine* for details about the impending lab regulations as they become available. ▲

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## FROM THE ILLINOIS NEWS DEPARTMENT OF PROFESSIONAL REGULATION

*This information is reprinted from the Illinois Department of Professional Regulations's monthly disciplinary report. IDPR is solely responsible for its content.*

### OCTOBER 1991

Ana C.M. Castellanos, Chicago — physician and surgeon license reprimanded and she was fined \$500 after practicing while her license was in a nonrenewed status.

Naved Musharraf, Oak Brook — physician and surgeon license placed on probation for three years after he left a patient with an employee who was not qualified to administer the required care.

Richard A. McLaughlin, Houston, Texas — physician and surgeon license suspended indefinitely after his Texas license was disciplined for inadequate charting.

Tae Hyun Sung, Chicago — physician and surgeon license placed on probation for one year after he prescribed controlled substances for nontherapeutic reasons.

John W. Kaminski, Glenview — physician and surgeon license reprimanded and he was fined \$1,100 after practicing while his license was in a nonrenewed status.

Concepta M. Villanueva Lasquite, Wheeling — physician and surgeon license issued and reprimanded after she worked as a physician assistant without a license and performed duties which may have constituted the unlicensed practice of medicine.

### NOVEMBER 1991

Alicia Crawford, Chicago — physician and surgeon license placed on probation for one year and fined \$2,600 after failing to comply with consent order previously issued by Department.

Thomas S. Jhee, Marietta, Georgia — physician and surgeon license suspended indefinitely after Georgia license was disciplined for unprofessional conduct and prescribing for other than legitimate medical purposes.

James C. Andre, St. Paul, Minnesota — physician and surgeon license revoked after failing to answer a complaint filed against him by Department.

John B. Barnes, Los Angeles, California — physician and surgeon license revoked after California license was disciplined following felony and possession of a controlled substance conviction.

John Palmer, Chicago — physician and surgeon license suspended indefinitely until satisfactorily completing payment of taxes determined by the Department of Revenue.



# Congratulations! The waiting is over for Illinois medical students

by Anna Brown

MATCH DAY has come and gone, and Anu Natarajan, John Buegler and Richard Guttman, three Illinois medical students profiled in the March 13 issue of *Illinois Medicine*, heard good news on March 18. They all matched with residency programs high on their lists.

"I'm very excited, and a little nervous," said Natarajan, from the Southern Illinois University School

of Medicine. She matched with her first choice: the pediatrics primary care track residency program at the University of California - Los Angeles. "I really liked it. It's a big medical center, which will give me the opportunity to see a lot of things."

Guttman also received his first choice, and won't have to make a big move. He will graduate from the University of Illinois at Chicago, and join its residency program in the summer. "I know people at

U of I, and I get along well with them," he said. "That's as important to a job as anything else. I'm very happy. Luckily, everything worked out."

Buegler, from the University of Chicago, will join the Barnes Hospital residency program in St. Louis, which he said ranked high on his list. "This gives me the opportunity to stay in the Midwest, and I'm really happy about it," he said. ▲



From left: Anu Natarajan of SIU School of Medicine in Springfield; Richard Guttman of the University of Illinois at Chicago, with his wife, Tammy; and John Buegler of the University of Chicago.

## Match (continued from page 1)

completely."

Smith said all three internal medicine tracks filled completely, and that out of 60 ranked match candidates the program did not dip below No. 21 on the list. "In fact, four of our 12 available positions fell within our top 10 choices, which is really exciting," she added.

Despite its internal medicine success, UI's family practice program did not match any of its four slots. Smith attributed this to the lack of family practice applicants nationwide, and to the fact that the UI program is in its "baby stages" after starting up last year. "Everything we did this year will be reviewed so we can do better in the future," she said.

But there is better news for other Illinois family practice programs, which have made steady gains in the last few years. Of the 138 available slots in Illinois, 83, or 60 percent, matched this year, up 3 percent from 1991. Only five family practice residency programs did not match any available slots this year, while five programs filled completely. There are 55 family practice positions still open, down from last year's 60. Residency program directors anticipate an increase in post-match family practice candidates this year and in the future.

Jerry Kruse, M.D., associate professor of family practice at the Southern Illinois University School of Medicine and director of the Quincy Family Practice Residency Program, said that while his program did not fill any positions on Match Day, he expects to fill the three empty slots.

"We had interviewed students outside the match, and made offers on Match Day," Dr. Kruse said, noting that two of the non-match students accepted.

"There was a much larger number of family practice candidates this year, and we'll have no trouble fill-

ing the program," Dr. Kruse said. "It was very difficult last year, but the outlook is much brighter. Already we have more application requests for 1993 than 1992, and overall more people matched in family practice this year. We may never get back to the glory days of the 1970s, but I'm much more confident now."

Methodist Medical Center in Peoria is one of the five family practice programs that filled completely, according to program director Fred Z. White, M.D. Methodist is affiliated with the University of Illinois College of Medicine at Peoria. The program will take in nine first-year residents - two more than its available match slots. One candidate signed on before Match Day, and another joined whose husband was already in

the program, he said.

"We're very pleased to have done this well," said Dr. White, whose program matched five out of eight positions in 1991.

All residency positions except for two family practice slots were filled at St. Joseph Hospital in Chicago. "It has been different in the past for us in internal medicine," said Serafino Garella, M.D., chairman of the department of medicine and internal medicine residency program director at St. Joseph. "There has been a decrease in applications over the last few years, and the trend is continuing. But I believe we have a well-structured and satisfying teaching program. This year we were more aggressive in actively pursuing quality candidates, and that's why we filled." ▲

## Obituaries

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

### \*Bernstein

Max M. Bernstein, M.D., of Palatine, died January 13, 1992 at the age of 78. Dr. Bernstein was a 1937 graduate of Rush Medical College, Chicago.

### \*Fox

Robert T. Fox, M.D., of Friday Harbor, Wash. (formerly of Evanston), died September 1, 1991 at the age of 75. Dr. Fox was a 1942 graduate of Northwestern University Medical School, Chicago.

### \*Holt

Helen Holt, M.D., of Wilmette, died January 11, 1992 at the age of 91. Dr. Holt was a 1934 graduate of Rush Medical College, Chicago.

### \*Howland

Bernard F. Howland, M.D., of Aurora, died December 29, 1991 at the age of 82. Dr. Howland was a 1942 graduate of Chicago Medical School.

### \*Komajda

Raymond M. Komajda, M.D., of Niles, died January 14, 1992 at the age of 75. Dr. Komajda was a 1951 graduate of Chicago Medical School.

### \*\*Kraft

Alexander C. Kraft, M.D., of Rockford, died February 8, 1992 at the age of 81. Dr. Kraft was a 1937 graduate of Northwestern University Medical School, Chicago.

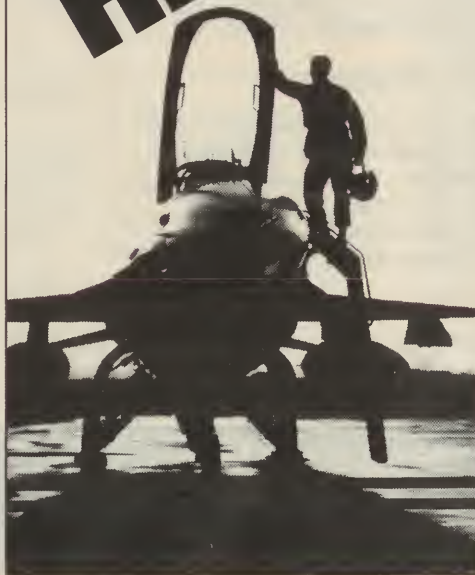
### \*\*Sadlek

Lawrence A. Sadlek, M.D., of Chicago, died October 25, 1991 at the age of 86. Dr. Sadlek was a 1931 graduate of Rush Medical College, Chicago.

### \*Watters

Charles L. Watters, M.D., of Cape Coral, Fla. (formerly of Geneseo), died November 6, 1991 at the age of 82. Dr. Watters was a 1937 graduate of Chicago Medical School.

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## ADA compliance deadlines

**Jan. 26, 1992** – Practices with 26 employees or more, or annual gross receipts of \$1 million or more, required to meet public accommodation provisions, including standards for new construction.

**July 26, 1992** – Practices with 25 employees or more required to meet employment provisions.

**July 26, 1992** – Practices with 11-24 employees or fewer, or annual gross receipts of less than \$1 million, required to meet public accommodation provisions.

**Jan. 26, 1993** – Practices with 10 employees or fewer and gross receipts of \$500,000 or less, required to meet public accommodation provisions.

**Jan. 26, 1994** – Practices with 15-24 employees required to meet employment provisions.

## Americans with Disabilities Act

(continued from page 1)

tients.

There are three areas that physicians will have to become familiar with to comply with the Act, Marshall-Cohen says. The first is Title I, which covers employment issues. Specifically, employers must ensure equality in job application procedures, hiring, advancement and discharge practices, and job training.

"Physicians need to recognize that they are considered employers under the Act or they may be an employee of a hospital or [some other entity]," she says. She stresses, however, that, "This is an equal opportunity act, it is not a quota bill."

Access to public accommodations, covered in Title III of the Act, in-

clude the other two areas of compliance with which physicians must be concerned. These cover physical access to facilities and what is described as access to programs and services.

### A lesser standard

While new construction must be totally accessible, existing structures will have to meet a new standard known as "readily achievable barrier removal." In most instances modification will be necessary, but the degree of modification can vary according to the nature of the barrier to be removed, practice size, location of practice and other factors. "It doesn't mean you have to retrofit your facilities," says Marshall-Cohen. "It is very clearly a lesser standard."

Ensuring effective communication between physician and hearing-impaired or visually-impaired patients falls under the access to program and services provisions. Hiring sign language interpreters for hearing-impaired patients may or may not be required. If effective communication with the patient can be achieved through writing notes to the patient, then that may be sufficient. Similarly, providing materials in braille for visually impaired patients may or may not be necessary.

"The law says that each place of public accommodation has to determine what is reasonable for that business," Marshall-Cohen says. "A physician's office might be expected to do less in this area than a hospital, which has more resources." She notes that while most hospitals and other large businesses have had to make these accommodations for some time, the extension of the law into doctors' offices is new. Consequently, interpretation regarding compliance in this area is still very subjective.

*Illinois Medicine* will explore each of these compliance areas in more detail in future articles.

Businesses with 26 employees or more, or gross receipts of \$1 million or more, were required to meet the public accommodation provisions, including standards for new construction, by Jan. 26. But practices which have 25 employees or fewer, or annual gross receipts of less than \$1 million, have until July 26 to comply with the public accommodation provisions. And practices with 10 employees or fewer and gross receipts of \$500,000 or less have until Jan. 26, 1993.

Practices with 25 employees or more also were to have met the employment standards by Jan. 26. Practices with 15 to 24 employees are required to meet employment provisions by Jan. 26, 1994.

The American Medical Association recommends that physicians contact several government offices for information on compliance with the Act. Information on the public accommodations requirements is available from the U.S. Justice Department Office of ADA at (202) 514-0301. Information on the employment provisions can be obtained from the Equal Employment Opportunity Commission at (800) 669-3362. The Architectural and Transportation Barriers Compliance Board, a non-profit group, also publishes compliance guidelines for public accommodations. They can be reached at (800) USA-ABLE. ▲



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Choose Butterworth Hospital in Grand Rapids, which serves a population of 700,000, plus a 13 county referral area, or a small community or rural environment at one of the affiliate hospitals. Grand Rapids is West Michigan's cultural, educational, and economic center. With Lake Michigan only 30 miles away and numerous forests and parks nearby, there are ample opportunities for recreation and entertainment. Listed below are a few of the many opportunities available.

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• **Family Practitioner/Private Practice** Three well established and thriving group practices at Butterworth Hospital desire to expand by adding an additional BC/BE family practitioner. Join existing groups consisting of 2 - 5 physicians, OB optional. Desirable call schedules, competitive salaries and benefit packages.

• **Family Practitioner/Urgent Care Center** Join the growing field of ambulatory care, Med+Center BC/BE family practitioner needed to provide medical services to patients on a regularly scheduled basis. No call schedule, flexible hours, excellent compensation and benefits.

• **Family Practitioner/Primary Care Clinic** BC/BE family practitioner or internist needed for a large, primary care medical and dental clinic in Grand Rapids. The clinic is managed by Butterworth Ventures, the largest health care system in West Michigan and funded by private donations and a federal grant. Staffing includes 2 family practitioners, a pediatrician, nurse practitioner, medical director and support personnel. This is a salaried position with a competitive compensation and benefit package and 1 in 5 call schedule.

• **Internal Medicine/Faculty Position** Board certified general internist with teaching and clinical skills needed to join dynamic full-time academic faculty for internal medicine residency. Responsibilities include direct patient care in faculty practice, supervision and teaching of residents and students in both outpatient and inpatient settings. Competitive salary and benefits. Protected time is available for research and teaching.

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The primary focus of this article will be to discuss the recent changes in identifying and reporting evaluation and management services that occurred as a result of the implementation of PPR. Essentially, the 90000-90699 series of CPTcodes has been deleted from the 1992 edition of the AMA's CPT-4 (the basis for reporting physician services under Medicare Part B). This article is intended to outline the coding changes, provide you some step-by-step help in making an appropriate coding choice and advise you of other policy changes that may impact your claim completion and Medicare billing techniques.

First, Some Background:

As you are aware, effective January 1, 1992, the Health Care Financing Administration (HCFA) implemented the Physician Payment Reform (PPR). PPR is a radical change in the method used by HCFA to reimburse physicians for services rendered under the Medicare Part B program. This article will not dwell on the mechanics and methodologies used in determining this complex reimbursement schedule for Medicare. Suffice it to say that the reimbursement is now based on a system called RBRVS (Resource Based Relative Value Scale.)

RBRVS is designed to calculate and compensate the "resources" used in providing care to Medicare beneficiaries. As such, it is intended to compensate physicians for their actual "work", overhead practice expenses and malpractice expenses.

How Does This Translate into Coding Changes?

When the HCFA and Harvard based study group evaluated the various medical services provided to beneficiaries, they found the current definitions for evaluation and management (E/M) services to be too vague and too broad to define the specific work provided during an E/M encounter. The new codes are designed to reflect the actual level of "work" provided during the various levels of these visits. The codes are designed to consider "eyeball to eyeball" physician/patient contact in office settings and floor/unit time in hospital settings. The new codes are based primarily on the extent of history, examination and level of medical decision making.

What Codes Are Changed:

Only those codes considered to be evaluation and management services are affected. E/M services include hospital inpatient visits, consultations, follow-up consultations, emergency room services, nursing home visits, home health care visits and services provided in a physician's office or other out-patient department settings. All other codes are not impacted, with the following exceptions: 1) the entire Medicine section, except the Evaluation Management Codes, has been moved to the back of CPT. PLEASE NOTE: the existing codes for medicine have not been renumbered; 2) the AMA CPT editorial panel has made some additions and deletions to the various procedural sections of the coding manual.

Can I Crosswalk Codes - Is a 90040 now a 99213?

No. The revised codes are a new way of classifying physicians' services. They are not merely a replacement or interchange of one code for another. Some caution is worth noting here: Many consultants have advised or led physicians to believe that there is a crosswalk of old codes to new codes - this is not so. While some payors may have developed statistical interchanges to facilitate payment for these services, those interchanges are not a valid crosswalk to define the services rendered during particular patient encounters. If you do use a "crosswalk" tool, please be sure you have met and can document each of the key elements for the code you select. These factors are discussed below.

Are the Old Definitions of Levels of Service the Same?

No. The new codes reflect physician work components such as taking a history, performing a physical exam and medical decision making. As such, each code must reflect the specific level of work provided for the particular component. Each code has several key components that must be met or exceeded in order to justify the use of a particular code. Key and contributory components may utilize similar terminologies but they are unique only to the particular component.

Selection of a Code:

When Selecting an E/M code, you must consider the following items:

- Level of history taken,
- Level of physical examination,
- Type of medical decision making,
- Any Coordination of Care,
- Nature of the presenting problem,
- Amount of counseling provided, and
- Time

LET'S REVIEW EACH OF THESE FACTORS:

The first three items are considered key components. These three factors must be considered for each level of coding option.

Histories are subdivided into the following four components:

- Problem focused - considers the chief complaint and brief history of present illness.
- Expanded problem focused - considers chief complaint, brief history of present illness and problem pertinent system review.
- Detailed - considers chief complaint, extended history of present illness, extended system review and pertinent past, family and/or social history.
- Comprehensive - considers chief complaint, extended history of present illness, complete system review and complete past, family and social history.

Examination also has four levels:

- Problem focused - is a limited exam of the particular affected body area/organ system.
- Expanded problem focused - is an exam of the particular affected body area/organ system and other symptomatic or related organ systems.
- Detailed - is an extended exam of a affected body area and other symptomatic or related organ systems.
- Comprehensive - is a complete single system specialty exam or comprehensive multi-system exam.

The levels of history and examination items do not need to be the same. You may have situations where you may have provided a detailed history, but only performed a problem focused examination. You should review each of these definitions and determine which level of history and examination apply to your case.

Medical Decision Making: There are four levels of medical decision making. Each of these levels has three components. This is perhaps the most critical element of E/M code selection. Remember that PPR reimbursement is based on the work involved during an encounter. Your medical decision/judgment process is an essential part of that work component. Below is a matrix reprinted from the AMA's CPT 1992 that outlines the components necessary for the four levels of medical decision making.

Level	COMPONENTS		
	Diagnosed/Treatment Options	Test Ordered Data Reviewed	Risks of Morbidity/ Mortality for Patients
Straightforward	Minimal	Minimal/None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

In order to determine which level of medical decision is appropriate for your case, you need to meet or exceed the required components in two of the three categories. For example: If you order an extensive battery of diagnostic tests or need to review extensive clinical data but there is minimal risk to the patient and there are limited treatment options/diagnosis: you have low complexity decision making, because you have met or exceeded only the low complexity

indicators in two categories. Conversely, if you have minimal treatment options and minimal risk but ordered an extensive array of diagnostic tests, you only have a straightforward decision making because you have not exceeded two out of three indicators for straightforward decision making.

Time: CPT identifies a time component as a guideline only. Time is not considered to be a factor in code selection unless 50% or more of the encounter involves education or counseling of the patient about a particular course of action, risks, benefits of particular service, treatment modality, etc. For example, while a particular encounter may only last 15 minutes, if you have provided (and can document) a detailed history, detailed examination and a high complexity of medical decision making, you can bill the more comprehensive level of E/M code, even though CPT may indicate a minimal time allotment for the code selected.

Do not be afraid to utilize the appropriate code to describe your services. However, your medical record documentation should, as in the past, be adequate to support the levels of care provided and subsequently billed, i.e. make sure your documentation reflects each of the three key components. You do not need to time stamp your medical records or claims to document the amount of time spent in providing care. However, if your only service component is counseling, noting the time in the record may be helpful.

Mix/Match:

In making a code selection for an evaluation/management service, the level of medical decision making must be considered in addition to the levels of history taken and examination performed. Keep in mind that proper code selection involves the selecting of the proper level of each of the key components.

E/M code selection is not necessarily a simple process. As you can see from the discussion above, there may be instances where a "mix and match" of each of the levels of key components will allow you to appropriately select a more comprehensive code based on the extent/level of history, examination and medical decision making.

Note: in reviewing the levels of key components, codes for new patient visit codes and new patient consultations require that all three of the required key components for particular E/M codes must be met or exceeded. Follow-up office visits for established patients and follow-up inpatient consultations may require that only two of the three key components be met. As an example, for a new patient, office or other outpatient service; if you have provided a comprehensive history and comprehensive examination but have straightforward medical decision making you can only report procedure code 99202 since you have not exceeded the three key components necessary to report either 99203 or 99204 (the more comprehensive levels of evaluation/management services).

However, if in the example above, you provided a comprehensive history, comprehensive examination and low complexity decision making you now have met or exceeded the three key components required for procedure code 99203.

Code Selection:

Here are seven steps to help you in selecting the appropriate E/M Code:

- 1) Identify the category of service, place of service and type of patient.
  - Consider the category of service. Is it a hospital follow-up visit, consultation, office visit or emergency room service, etc.
  - Consider the place of service. Codes that reflect office based consultation will probably be rejected if the place of service shows that the service was rendered in an inpatient setting. Hospital follow-up codes will likely reject if billed showing place of service as office, etc.
  - New patient and established patient definitions are changed. A new patient is considered to be one who has not seen the physician within the past three years. The three year rule applies to group practices with common record keeping as well. If a patient has been seen by a member of the "group" within the last three years, he is an established patient even if he is seeing a different physician.
- 2) Review the Appropriate CPT reporting Guidelines for the category:
  - New guidelines may provide specific instructions for using a particular category of codes. For example, initial hospital care coding by the admitting physician should reflect any other services related to the admission that were provided on the same day in other settings as well as in the inpatient setting. In other words, E/M services provided on the same date as the admission but provided in other settings by the admitting physician should not be billed separately.
- 3) Review the required levels of service descriptions for the code being chosen. In other words, what are the levels of the key and/or contributory components that must be met in order to use the particular code? The chart on the reverse side of this insert will provide a reference of the new codes and key components that must be met in order to report various codes.
- 4) Determine the extent of the history. Review CPT definitions of various levels. Discussed above.
- 5) Determine the extent of the examination. Review CPT definitions of various levels. Discussed above.
- 6) Determine the type/complexity of medical decision making involved. Review CPT definitions of various levels. Discussed above - see matrix.
- 7) Finally, select the appropriate E/M code keeping in mind the following points:
  - All of the key components for a particular code must be met when reporting the following services: new patient office visits, office consultations, initial patient consultations, emergency department services, comprehensive nursing facility assessments, confirmatory consultations and new patient home/domiciliary care.
  - Only two of the three key components must be met when reporting the following services: established patient office visits, subsequent hospital care, follow-up inpatient consultations, subsequent nursing home care and established patient home/domiciliary care.
  - When counseling and/or coordination of care dominates the physician/patient encounter (i.e., more than 50% of the visit), then time is the guiding factor toward code selection. The "average" time for particular codes is noted in the CPT discussion for each E/M code. As noted above, you don't need to time stamp medical records. However, if time is the only factor used in code selection, you should document the nature and extent of counseling and/or coordination of care in the medical record.

Global Surgery:

While the CPT procedural codes are essentially unchanged, Physician Payment Reform now includes some pre-operative services and routine follow-up care in a global surgical package. Depending on whether or not the procedure is considered to be major or minor, post-operative care may be included in the surgical reimbursement for either a 90-10-0 day period. There are some exceptions to this rule for the following: surgical cases or visits unrelated to the initial surgery; return trips to the surgical suite for complications related to the surgical procedure and unrelated services on the same day by the same or a different physician. Each of these exceptions should be identified with the appropriate modifier:

- 24 - Unrelated Evaluation and Management service by the same physician during a post-operative period.
- 25 - Significant, separately identifiable E/M service by same physician on the day of a procedure.
- 78 - Return to operating room for a related procedure during post-operative period. The carrier may reduce reimbursement for a second surgical procedure.
- 79 - Unrelated procedure or service by the same physician during the post-operative period.

Outlined below are the essentials of the new HCFA global surgical package:

"Scopies:" There are no post-operative packages for Endoscopies and most Catheterizations. You may need to clarify particular procedures with the carrier.

Major Procedures:

- All pre-operative visits by the surgeon that fall within one day of the surgical procedure are included. HCFA has indicated that it will closely review surgical care billing to detect increases in pre-op work up that fall 2 or 3 days prior to the procedure (as currently allowed under the global billing package) to determine if "abuses" to this policy warrant a change, i.e., expansion of the package.



- 90 day routine post-operative care. In other words, no billing is allowable for services or visits related to the surgical procedure if provided within 90 days of the date of surgery.
- Initial Work up and/or consultation prior to surgery by the surgeon, even if on the same day, are allowable. Any other services must be separate and distinct from the surgical procedure in order to be payable by Medicare.

#### Minor Procedures:

- 10 day routine post-operative visit package.
- No same day visit will be allowed by the carrier in addition to a surgical procedure, unless the visit is for a distinct and separately identifiable service.

The carrier has indicated that the starred (\*) procedures in CPT are generally considered minor surgical procedures. ISMS is aware that many other procedures are performed as "day surgery" in physician offices and hospital outpatient departments that are not listed as a starred procedure in CPT and may be considered as "minor" but are subject to the 90 day post-operative visit package limitations. The Society is aggressively pursuing clarification of this issue for its members. You may want to contact the carrier to verify the post-operative period for a specific procedure(s).

#### EKG Interpretation:

Under Physician Payment Reform, physicians are prohibited from billing for EKG interpretations as a separate procedure. Specifically, this billing prohibition applies to the following procedure codes: 93000, 93010, 93040 and 93042. If the global codes of 93000 or 93040 are billed, Medicare will only pay the technical component. Payment can still be made for interpretation of

other various specialized EKG codes including ECG and Holter monitoring procedures. Finally, Medicare will continue to pay the technical component-only for codes 93005 and 93017.

#### Summary:

Medicare has not expanded or changed its coverage policies in response to "new" guidelines for billing E/M services. Its policies on concurrent care, consultations and telephone services are unchanged. Additionally, the requirement to notify patients of estimated charges, Medicare payment and their out-of-pocket expense for surgical charges of \$500.00 or more when the physician does not accept assignment is still in effect. This does not apply to emergency surgeries.

To avoid unnecessary claim rejections, remember to be specific in selecting a diagnosis and procedure code to report the services you provided. Additionally, you should report only the services you provide and the diagnoses you treat. In billing Medicare, you are submitting a claim for payment not a medical record.

Reporting a diagnosis or patient condition that you do not personally treat may cause a claim rejection for concurrent care or violation of the post-op billing package for another physician who is treating that condition. Additionally, proper use of modifiers when appropriate and noting the name of the requesting physician when billing for consultation and "ordered" services will help to minimize claim rejection.

Please do not hesitate to call ISMS Department of Economics if you have questions or require clarification of the issues outlined in this article or in other Medicare Part B policies/procedures.

	CPT Code	KEY COMPONENTS			SECONDARY COMPONENTS		
		History	Examination	Medical Decision Making	Counseling and/or Coordination	Nature of Presenting Problem	Time (minutes)
Office or Other Outpatient Services, NEW Patient (3 of 3 Key Components Required)	99201	Problem Focused	Problem Focused	Straight-forward	As Needed	Self Limited or Minor Severity	10
	99202	Expanded Problem Focused	Expanded Problem Focused	Straight-forward	As Needed	Low to Moderate Severity	20
	99203	Detailed	Detailed	Low Complexity	As Needed	Moderate Severity	30
	99204	Comprehensive	Comprehensive	Moderate Complexity	As Needed	Moderate to High Severity	45
	99205	Comprehensive	Comprehensive	High Complexity	As Needed	Moderate to High Severity	60
Office or Other Outpatient Services, ESTABLISHED Patient (2 of 3 Key Components Required)	99211	Problem may not require presence of physician			As Needed	Minimal	5
	99212	Problem Focused	Problem Focused	Straight-forward	As Needed	Self Limited or Minor Severity	10
	99213	Expanded Problem Focused	Expanded Problem Focused	Low Complexity	As Needed	Low to Moderate Severity	15
	99214	Detailed	Detailed	Moderate Complexity	As Needed	Moderate to High Severity	25
	99215	Comprehensive	Comprehensive	High Complexity	As Needed	Moderate to High Severity	40
Initial Hospital Care (3 of 3 Key Components Required)	99221	Comprehensive	Comprehensive	Straight-forward or Low Complexity	As Needed	Low Severity	30
	99222	Comprehensive	Comprehensive	Moderate Complexity	As Needed	Moderate Severity	50
	99223	Comprehensive	Comprehensive	High Complexity	As Needed	High Severity	70
Subsequent Hospital Care (2 of 3 Key Components Required)	99231	Problem Focused	Problem Focused	Straight-forward or Low Complexity	As Needed	Patient Stable, Improving	15
	99232	Expanded Problem Focused	Expanded Problem Focused	Moderate Complexity	As Needed	Patient Responding Inadequately/Complications	25
	99233	Detailed	Detailed	High Complexity	As Needed	Patient Unstable or Significant Complications	35
Hospital Discharge Services	99238	Hospital Discharge Day Management (Should not be billed if Initial or Subsequent Hospital Care billed for day of discharge)					
Office or Other Outpatient Consultations (3 of 3 Key Components Required)	99241	Problem Focused	Problem Focused	Straight-forward	As Needed	Self Limited or Minor Severity	15
	99242	Expanded Problem Focused	Expanded Problem Focused	Straight-forward	As Needed	Low Severity	30
	99243	Detailed	Detailed	Low Complexity	As Needed	Moderate Severity	40
	99244	Comprehensive	Comprehensive	Moderate Complexity	As Needed	Moderate to High Severity	60
	99245	Comprehensive	Comprehensive	High Complexity	As Needed	Moderate to High Severity	80
Initial Inpatient Consultations (3 of 3 Key Components Required)	99251	Problem Focused	Problem Focused	Straight-forward	As Needed	Self Limited or Minor Severity	20
	99252	Expanded Problem Focused	Expanded Problem Focused	Straight-forward	As Needed	Low Severity	40
	99253	Detailed	Detailed	Low Complexity	As Needed	Moderate Severity	55
	99254	Comprehensive	Comprehensive	Moderate Complexity	As Needed	Moderate to High Severity	80
	99255	Comprehensive	Comprehensive	High Complexity	As Needed	Moderate to High Severity	110
Follow-up Inpatient Consultations (2 of 3 Key Components Required)	99261	Problem Focused	Problem Focused	Straight-forward or Low Complexity	As Needed	Patient Stable, Improving	10
	99262	Expanded Problem Focused	Expanded Problem Focused	Moderate Complexity	As Needed	Patient Responding Inadequately/Complications	20
	99263	Detailed	Detailed	High Complexity	As Needed	Patient Unstable or Significant Complications	30
Confirmatory Consultations (3 of 3 Key Components Required)	99271	Problem Focused	Problem Focused	Straight-forward	As Needed	Self Limited or Minor Severity	-
	99272	Expanded Problem Focused	Expanded Problem Focused	Straight-forward	As Needed	Low Severity	-
	99273	Detailed	Detailed	Low Complexity	As Needed	Moderate Severity	-
	99274	Comprehensive	Comprehensive	Moderate Complexity	As Needed	Moderate to High Severity	-
	99275	Comprehensive	Comprehensive	High Complexity	As Needed	Moderate to High Severity	-



tary reporting mechanism of HIV-positive health care workers is integral to the success of implementing S.B. 999.

The group remained uncertain, however, how to resolve the inherent inability to safeguard an HIV-positive health care worker's confidentiality, while having the public health department monitor a provider's actions if limits are placed on his or her clinical practice. Once an HIV-infected health care worker is identified, the task force recommends convening an expert panel to determine if the health care worker poses a significant risk of HIV transmission to patients. The panel should be made up of an infection control practitioner, an infectious disease specialist

well-versed in HIV issues, an IDPH representative, an ethicist, the health care worker's own physician, a health professional with expertise in the procedures performed by the infected worker, and the infected health care worker or designee. The recommendation is consistent with guidelines established by the U.S. Centers for Disease Control.

The task force indicated its support for the expert review panel to report any practice limitations to IDPH and recommended the department monitor the worker to assure adherence to the restricted clinical practice. The task force was unable, however, to settle the issue of how the department will monitor these individuals without abrogating confidentiality. The group will continue to work for a solution on this issue.

The task force reiterated its opposition to mandatory continuing medical education for all health care workers. The group maintains that mandated infection control training and strict adherence to universal precautions required by the new U.S. Occupational Safety and Health Administration rules on transmission of bloodborne pathogens in health care settings are sufficient. Task force members also rejected the concept of requiring documentation of infection control training as a condition of relicensure.

Also still unresolved is the cost of implementing the law. The General Assembly appropriated \$500,000 to enact the legislation, and with the state's fiscal condition forcing the governor to recommend steep budget cuts in his upcoming fiscal 1993

budget, that amount is not expected to increase. Dr. Dekker expressed uncertainty about the state's ability to administer a conscientious notification program for that amount.

As an example, he cited an AIDS look-back study performed in Minnesota that cost \$149,000 for a single exposure incident. Illinois spent about \$30,000 last fall to test the patients of the Nokomis dentist who died of AIDS. Although this testing program was significantly less costly than the Minnesota study, it carried a high emotional cost for the dentist's patients, none of whom tested HIV positive. The task force expressed its hope that future notification efforts would be more focused, notifying and recommending HIV testing only for those patients who actually were at risk. ▲

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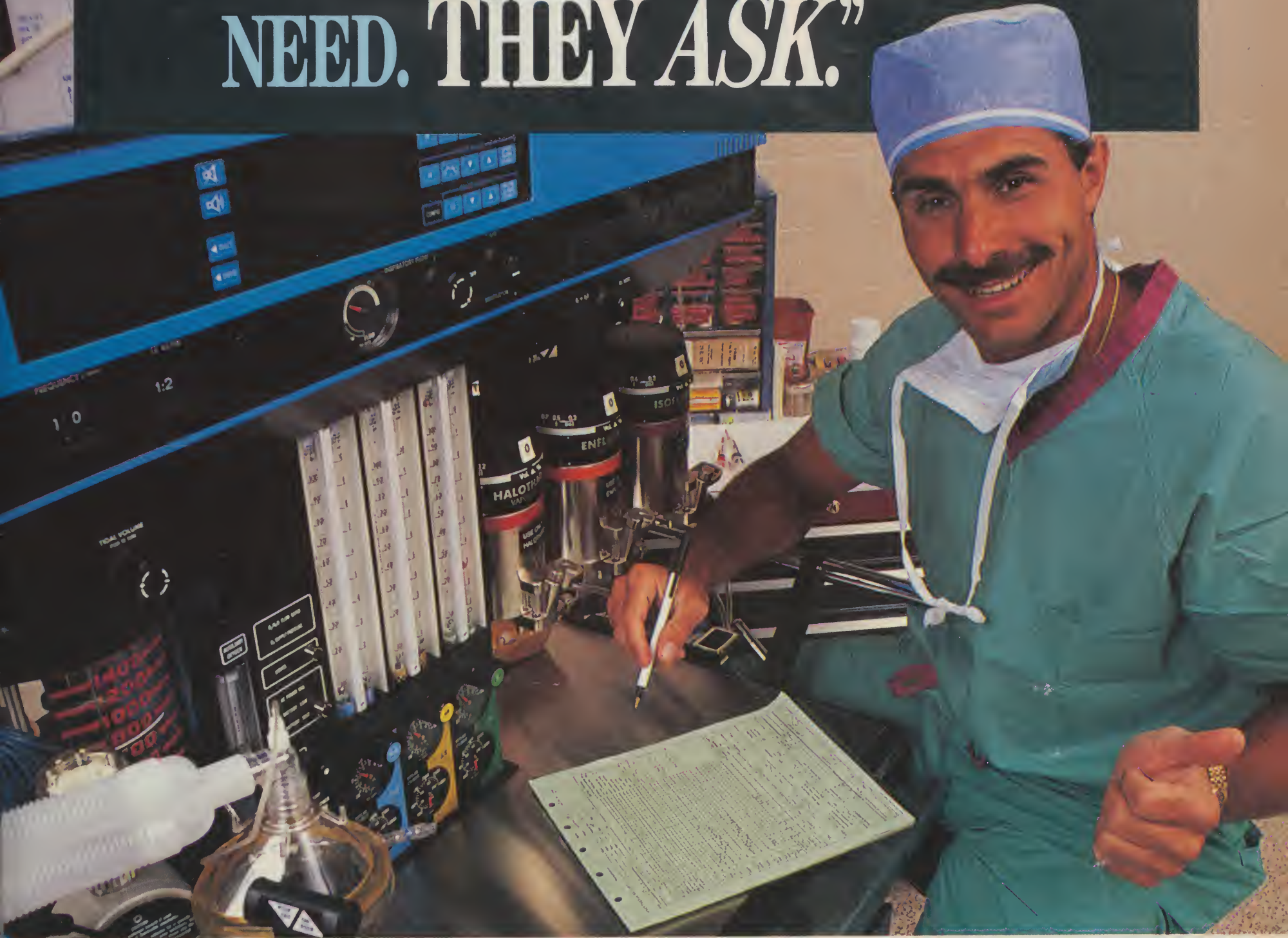
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- No adverse effects on total cholesterol, plasma glucose levels, renal function,<sup>‡</sup> or serum electrolytes<sup>3-6</sup>



For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

**References:** 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil In Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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# Illinois Medicine

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April 24, 1992

ILLINOIS STATE MEDICAL SOCIETY

## Discounts offered Exchange rewards good loss records

by Anna Brown

INTRODUCING A variety of money-saving opportunities for physicians, the Illinois State Medical Inter-Insurance Exchange is gaining momentum in its Focus on Service initiative for 1992-93. Harold L. Jensen, M.D., chairman of the Exchange Board of Governors, announced several significant and exciting new programs and favorable rate changes at the Illinois State Medical Society annual meeting.

"Let me say on behalf of myself and your Exchange Board of Governors how pleased we are to bring you this favorable report on rates for the coming year," Dr. Jensen told the House of Delegates April 10. "The Exchange remains in a strong financial position. Our strength, however, is you, our policyholders, who have established the Exchange as a physician-owned company, operated by physicians to meet the needs of Illinois physicians."

### Loss-free discount

Perhaps the most notable news was Dr. Jensen's

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## House of Delegates changes bylaws, enacts public health policy

by Kevin O'Brien

BYLAWS CHANGES limiting terms of office for officers and trustees and new policies on selected public health issues marked the Illinois State Medical Society's 1992 annual meeting of its House of Delegates.

The meeting was held Friday through Sunday, April 10-12, at the Oak Brook Hills Hotel in Oak Brook. In addition to debating almost 90 resolutions, delegates elected new officers, trustees and delegates to the 1993-94 meetings of the American

(continued on page 13)



Robert M. Reardon, M.D., (left) receives a scrapbook highlighting his year as ISMS president from his successor, Arvind K. Goyal, M.D., April 12 at the ISMS annual meeting.

Wm. Daniels/The Photo Partners

## New construction or alterations require full compliance with ADA

by Kevin O'Brien

A GROUP OF physicians are planning to build an outpatient surgical center or new clinic.

Or perhaps a physician is planning substantial renovation to his or her office.

Whichever it is, before going any further, it is clear the physicians owe it to themselves to become immediately aware of their obligations under the new federal Americans with Disabilities Act.

"The [ADA] is deemed to be a civil rights law," says Earl B. Slavitt, attorney with Katten Muchin & Zavis in Chicago. "All things being equal, you must comply."

The Act, considered the



Second  
in a  
series

Amy Rothblatt

most comprehensive legislation of its kind, goes beyond the provisions of Section 504 of the Rehabilitation Act of 1973, which applied only to federal agencies or private or public agencies that received federal funding.

The new law, signed by President Bush in July 1990,

is designed to protect people with disabilities from any discrimination and to guarantee them equal access to the provision of goods and services.

The law defines disability as "a physical or mental impairment that substantially limits one or more of the major life activities of such an individual, having a record of such an impairment or being regarded as having such an impairment."

(continued on page 8)

### Call to action

## The Universal Health Care Act is back!

THE UNIVERSAL Health Care Act is back. S.B. 1495, sponsored by Sen. Margaret Smith (D-Chicago), and H.B. 2774, sponsored by Rep. Anthony L. Young (D-Chicago), claim that a single-payer public insurance system will solve Illinois' health care problems. It won't.

Call your state representative and state senator in Springfield at (217) 782-2000 immediately to prevent:

- A bureaucratic monopoly in the financing of Illinois health care
- A drastic increase in the demand and cost of health services
- The more than doubling of state income tax
- The imposition of a 7 percent payroll tax
- The rationing of health care services
- The total bureaucratic management of health care institutions and services
- A state government-run health care disaster

Urge your legislators to vote "no" on H.B. 2774 and S.B. 1495. For more information, call the ISMS Division of Governmental Affairs at (312) 782-1654 or (800) 782-ISMS. ▲

## Belleville medical community outraged over physician's day in jail

by Anna Brown

MEMBERS of the St. Clair County Medical Society expressed their outrage over the incarceration of a Belleville physician and two

attorneys on April 2, after the physician refused to answer a question pertaining to treatment of a former patient during a deposition.

James V. Vest, M.D., his personal attorney, Gerald L. Montroy, and an Illinois State Medical Inter-Insurance Exchange-retained attorney, Charlene A. Creemeens, were released after 5 1/2 hours in jail, having been found in contempt of court by Associate Judge James Radcliffe.

"This is beyond belief," said Ronald G. Welch, M.D., a Belleville physician and Illinois State Medical Society Tenth District trustee. "A busy physician should not be thrown in jail to satisfy a dispute over the interpretation of the law."

Dr. Vest and his attorneys were detained after he refused, on advice of counsel, to answer a question regarding the treatment of Melvin Roth, who died at St.

(continued on page 12)

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## Illinois infant mortality rate lowest in history

The state's infant mortality rate dropped by 9 percent to its lowest level in Illinois history, Gov. Jim Edgar announced March 23. The 1990 infant mortality rate decreased to 10.7 deaths per 1,000 live births, compared with an 11.7 mortality rate in 1989, according to the Illinois Department of Public Health. The state's previous low infant death rate was reached in 1988 at 11.2. The 1990 figures are the most recent statistics available.

"We are making progress, but we must continue to join together — government agencies with one another, the public sector with the private sector, the medical community with the social services community — to reduce the number of needless deaths," Edgar said. "We must strengthen our commitment to find innovative ways to improve pregnancy outcomes."

"Even in these tough fiscal times for state government, I increased funding for infant mortality initiatives by \$39 million," the governor continued. "I am committed to providing the funding necessary to maintain our momentum in reducing the infant mortality rate."

Infant deaths fell throughout the state, IDPH said. In Chicago, the infant mortality rate decreased to 15.6 deaths per 1,000 in 1990 from 17 in 1989, and downstate the rate dropped to 8.5 in 1990 from 9.3 in 1989. While these mortality rates were dropping, the actual number of births statewide grew to 195,499 in 1990 from 190,247 the year before.

"There are still too many babies who die before they reach the age of 1," said IDPH Director John R. Lumpkin, M.D., adding that Illinois' minority population faces a considerably higher infant mortality risk than its white counterparts. "Too many babies are being born sick or very small or into conditions of ex-

treme poverty, which disproportionately impact on minorities. We must continue to find innovative ways to educate mothers-to-be that early and comprehensive prenatal care, proper nutrition and family planning are crucial to having a healthy baby."

Illinois will spend \$150 million on infant mortality reduction programs in fiscal 1992, up \$39 million from 1991. One of these programs, IDPH's Families with a Future, served 40,000 women and their infants in 27 areas with high infant death rates in 1990. These women experienced lower overall infant mortality than women not in the program.

## House passes Higher Education Act without loan deferments

The U.S. House of Representatives March 27 passed its version of the Higher Education Act without voting on American Medical Association-supported amendments to extend student loan deferments for resident physicians. The amendments, aimed at preserving the current two-year deferment for residents and interns, were ruled out of order because they would violate the budget agreement of 1990, the AMA said.

In the final version passed by the House, the Act includes student loan deferments for medical students still in school, two-year deferments for unemployed medical school graduates and three-year deferments for graduates suffering economic hardship. The Senate passed similar legislation in February banning deferments for resident physicians, although the bill did preserve the doctors' rights to put their loans into forbearance, allowing them to forgo loan payments while racking up additional interest charges. ▲

— by Tamara Strom



Although forced to propose severe spending cuts in the fiscal 1993 budget because of the state's continuing financial crisis, Illinois Gov. Jim Edgar (left) was able to add money to selected preventive health programs. Among the governor's health priorities are infant mortality and AIDS programs. While many public aid programs took large cuts, the physician line will increase in 1993.

## Governor proposes budget cuts for public aid, increases for preventive health programs

by Tamara Strom

SAYING THERE are no "rivers of money flowing into Illinois," Gov. Jim Edgar announced his second recession-cramped budget rife with spending cuts and user fees. Despite the state's gloomy fiscal condition, Edgar moved to protect some health care programs and proposed others aimed at improving access to primary preventive health services.

*"We must continue to reject the notion that government can be all things to all people, difficult as it is to say 'no' to good causes."*

While the governor significantly reduced the public aid program, the physician line increases in fiscal 1993. Also, provided there is an adequate daily balance in the state treasury, the payment cycle for reimbursing physicians' Medicaid claims should be down to 60 days by the beginning of the fiscal year.

Although Edgar and the General Assembly negotiated tough budget cuts at the end of last year's legislative session in July and again sliced spending in January, failing revenues and poor economic forecasts forced yet another "austere" budget for fiscal 1993, Edgar said.

"We simply cannot afford to allow programs to grow without restraint, devouring resources that must be marshaled for essential, priority services and programs," Edgar said during his April 7 budget message. "We must continue to reject the notion that government can be all things to

all people, difficult as it is to say 'no' to good causes."

Edgar charged that Illinois must live within its means and not spend money that does not exist in the state treasury. To keep his "no new taxes" pledge, Edgar is proposing additional revenue measures, including "user fees" on alcohol, which indirectly costs the state about \$3 billion a year in alcoholism treatment, and increased levies on tobacco products not currently taxed, including pipe tobacco, chewing tobacco and snuff. But inherent in the governor's spending plan are significant cutbacks in the state's public aid program.

### Mandates 'fiscally murderous'

"There is a compelling need for us to better manage health care costs for state workers and for the poor. Those costs, especially in the Medicaid area, have spiraled virtually out of control for years," the governor said, adding that Medicaid now represents 70.9 percent of the total public aid budget. "Much of this increase is due to the federal government telling us what we can do, and cannot do, in the Medicaid area. The mandates, to put it bluntly, have been fiscally murderous."

Edgar said Illinois must develop a more "cost-conscious, more visionary and more compassionate approach to providing health care to the needy." He proposed a new program called "Healthy Moms, Healthy Kids" that would spend \$29 million to provide primary health care services to poor pregnant women and children in Chicago. Edgar said this preventive program will save the state money because these children and mothers will no longer have to rely on more costly emergency room care.

Under the plan, these Medicaid recipients would be required to receive their health care from a partici-

(continued on page 12)

## Physician Facts

### Infant mortality in Illinois

Infant mortality rates (deaths per 1,000 live births) for the entire state, selected counties, and Chicago:

	1990	1989
Illinois	10.7	11.7
Chicago	15.6	17.0
Suburban Cook	9.5	9.4
DuPage	6.6	5.0
Kankakee	11.2	12.7
Madison	7.9	9.2
McHenry	6.5	9.2
Peoria	13.0	9.0
Sangamon	7.7	9.2
St. Clair	13.6	14.5
Vermilion	9.6	12.5

Source: Illinois Department of Public Health.

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# New map, voter dissatisfaction add to new faces on political scene

by Tamara Strom

ANY REDISTRICTING year promises to be a watershed in the political arena. And because the new legislative maps based on the 1990 census were Republican-drawn, following 10 years of a Democrat-drawn map, bigger changes were expected in legislative races because of the newly configured districts. Illinois' March 17 primary didn't disappoint those who anticipated such sweeping change.

Replete with primary night surprises and familiar political standbys losing races in new districts, the primary laid the groundwork for a changing face in the composition of the Illinois Statehouse and U.S. congressional delegation.

"The number of new faces in the Illinois House and Senate this year is considerable," said Illinois State Medical Society Immediate Past President Robert M. Reardon, M.D. "Also the number of incumbents who went down to defeat either through redistricting or tough primary fights is notable. Between now and the end of the general election in the fall, we will see an evolving character of the legislature. Medicine can play a large role in this fluid situation. Physicians must not underestimate the importance of getting to know the candidates in their area who are responsive to medical issues."

## News Analysis

throughout the state was high for the primaries, and many female candidates benefited, including Braun. In traditional Republican strongholds, many Republican female voters took Democrat ballots for the sole purpose of voting for Braun, analysts report. Whether their intent was to vote for Braun or against Dixon no one can know, but the effect was clear — a victory for Braun over a heavily favored incumbent.

Crossover votes for Braun also had far-reaching effects in several General Assembly races. Observers indicate that the absent Republican votes in legislative races may have influenced

the defeat of at least two pro-choice female Republican candidates in the collar counties. In Lake County, Edna Schade and Dolores Axelrod lost to Charles Cardella. "Would those votes have made the difference in these races? No one can judge if it would have been a margin of victory," noted Harold L. Jensen, M.D., immediate past chairman of the Illinois State Medical Society Political Action Committee (IMPAC).

IMPAC contributed to more than 80 legislative primary races around the state. Dr. Jensen explained that tort reform was a major IMPAC concern in several races where medical-community-supported candidates were running against candidates

backed by the trial attorneys' lobby. Many medicine-supported candidates, such as Carolyn Krause in the new 56th House District, were victorious in the primary. But a few anti-tort reform candidates did rack up wins March 17, such as Al Salvi in the new 52nd District, whose brother is a well-known Lake County plaintiff attorney and incoming president of the Illinois Trial Lawyers Association.

Many Springfield insiders are predicting the upcoming General Assembly session will result in a "do-nothing legislature" because of the state's continuing fiscal crisis and the fear of legislators up for re-election to take chances in a redistricting

(continued on page 12)

## Blue Cross Blue Shield REPORT FOR Illinois Physicians

### CORRECTION TO TELEFAX NUMBER FOR FREEDOM OF INFORMATION REQUESTS

The February 1992 Medicare B Bulletin listed various reports available upon request from the Freedom of Information (FOI) Unit. Request should be made in writing to the Freedom of Information Unit or submitted by telefax. The telefax number for FOI requests is: (618) 997-7978. Please use this number for submitting telefax FOI requests rather than the one published in the February Bulletin.

### TELEPHONE CALLS

Attendees at many of our seminars ask -- "How do we bill for telephone calls?"

Medicare does not make separate payment for telephone calls. Our policy is that telephone calls are part of the physician work in the visit or service and that payment for the visit or service encompasses the payment for telephone calls. The work in the telephone calls is already included in the Relative Value Units (RVUs) for the visit or service since it is a part of the pre- and post- work of the visit or service.

Do not notify your patients that this is a non-covered service. It IS a covered service, bundled into the visit or service being rendered. It CANNOT be billed to your patient separately.

### PROGRAM INTEGRITY

Claims for DME, prosthetics or orthotics must be accompanied by a physician's prescription or certification of medical need, whether the item is rented or purchased. These Certificates of Medical Necessity (CMN), must be completed in full by the ordering physician and must include the patient's diagnosis, prognosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need. Again, the CMNs cannot, in any form or part, be completed by the supplier. CMNs may not be completed by a physician for a patient not professionally known to him.

### PROVIDER EDUCATION AND AUTOMATION UNIT

The Professional Relations and Electronic Media Claims units of Medicare B have been collectively renamed as Provider Education and Automation. The name change more accurately reflects the combined unit's function. Individual representatives from the former units will be able to handle inquiries concerning coverage and reimbursement in addition to electronic billing. The result will be more effective service to providers.

### SOCIAL WORKERS NOT COVERED

Psychological testing services are covered only if furnished by physicians or qualified psychologists, according to the Federal Register of November 25, 1991. As a result, psychological testing by clinical social workers is not a covered service.

### CORRECTION TO CARDIAC CATHETERIZATION PROCEDURES

In our February 1992 Bulletin, we noted that if the cardiologist performing the cardiac catheterization (93546-93553) also provides interpretation of the procedure, report these 2 separate services using the appropriate "cath" code with a -26 modifier, and the appropriate radiology supervision and interpretation code. Our example indicated that if both services were performed by the cardiologist, codes 93547-26 and 75754 should be billed, with no modifier on procedure code 75754. Because procedure code 75754 is a "global" procedure code, a -26 modifier is required to report the interpretation of the procedure.

(4/24/92)

*"Physicians must not underestimate the importance of getting to know the candidates in their area who are responsive to medical issues."*

The biggest surprise was in the Illinois Democrat primary Senate race where Cook County Recorder of Deeds Carol Moseley Braun upset long-time Democrat incumbent Alan J. Dixon, popular with Democrats and Republicans alike. Braun will face Republican Richard S. Williamson, who ran unopposed in the GOP primary, in the November general election.

Williamson, who served in the administrations of Presidents Reagan and Bush, is an attorney who serves on a committee that advises the Illinois State Medical Inter-Insurance Exchange.

The primary pitted Dixon against trial attorney Al Hofeld, who spent more than \$4 million of his personal money to turn the tide against Dixon by churning up anti-incumbent feelings in the electorate. While Hofeld and Dixon were bashing each other in a high-priced media campaign, Braun plugged away at Dixon's seemingly insurmountable lead. On election night, she walked away the winner.

Turnout among women voters



## Editorial

## Time to call your legislator again

**T**he Illinois State Medical Society believes the health care system should be improved. The concept of appropriate health care for all Illinois citizens is a noble goal the medical society supports.

ISMS contributed meaningfully to the health care reform debate by endorsing, at its April annual meeting, guidelines to improve the current health care system. Based on these principles, which are touched on in this issue's annual meeting story, and which will be fully detailed in the next *Illinois Medicine* issue, ISMS stands clearly in the corner of keeping what's right about the current system, and getting rid of what's wrong.

ISMS supports enhancement of preventive health measures, reform of the health insurance and government reimbursement systems, and malpractice reform as ways to control health care costs and maintain quality medical care.

ISMS believes that a single-payer, government-funded and -run health care system would not improve health care quality, would not control health care spending (indeed would dramatically increase what we now spend on health care) and would not be implementable.

Legislation calling for just such a system is pending in Springfield. Passage of this legislation would mean big increases in state income taxes and state payroll taxes, and turn a currently struggling state financial picture into chaos. Businesses would leave Illinois for states less costly to their operation. Labor union benefits contracts, fought for and negotiated, would no longer be valid. Medical providers, already being reimbursed at slow and low levels, would be further squeezed, and many would be forced to leave Illinois. It would weaken, not strengthen, access to care.

This legislation promises everything, and would be impossible to fund. Its supporters know that. They don't intend to fund it, if it passes. Supporters of H.B. 2774 and S.B. 1495, the Universal Health Care Act, are manipulating the health care reform issue for political gain. Just as Al Hofeld used his plaintiff attorney victories to posture as a champion of people, supporters are using this issue to attack the medical profession and to re-elect candidates.

On May 13, a "Campaign for Better Health Care" group has called for a rally in Springfield to attack the Illinois State Medical Society and support universal health care legislation. What can you do to stand up for the physicians of Illinois?

Write or call your legislator. Let legislators know how strong your support of patients is by encouraging the legislator to vote no on H.B. 2774 and S.B. 1495. Tell legislators, in your own words, about how measures such as caps on non-economic awards in malpractice suits will help control health care costs and improve access to care. Let legislators know that empty promises of "free" health care for all are irresponsible, when such promises cannot be funded. Show legislators you are offended by attempts to use sweeping promises of universal health care for political gain. Health care delivery is a complex issue; the health care system in Illinois and this country will not be improved by this bill. It will be destroyed. If you don't know who to write, call ISMS at 1-800-782-ISMS and ask for the Division of Governmental Affairs. ▲

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EYE CLINIC



"Excuse me, buddy, can you tell me how to get to the eye clinic?"

## President's Column

## Trying times are back

Newlyweds were starting to argue. "Darling, don't you think those four electric fans you had running all day are a wee bit extravagant?" But the bride in turn responded, "Don't worry about it, dearest. They're not our fans. I borrowed them from the neighbors."

Unfortunately, the same logic seems to drive those who persist in their efforts to duplicate a Canadian health care system here. As expected, the Universal Health Care Act is back in Springfield. In one of my first official acts as your president, I testified April 22 on this legislation before a joint hearing of the Illinois House Health Care Committee and the Senate Public Health, Welfare and Corrections Committee.

Last year, this proposal was defeated. Same time, same place and same talk! But encouraged by Minnesota's recent approval of a similar program, it has returned in the form of H.B. 2774, sponsored by Rep. Anthony L. Young (D-Chicago), and S.B. 1495, sponsored by Sen. Margaret Smith (D-Chicago), who chairs the Senate committee.

While universal access to health care is a goal we all strive for, it is not likely that a single-payer, government-run system can actually deliver what it promises without increasing overall costs and raising taxes, adversely affecting many employers. And all individuals – tall and short – may end up paying more for less.

Under the proposed legislation, state government would provide virtually unlimited "cradle to grave" care to everyone. Only cosmetic surgery – "look good" care – will be excluded. "Feel good" care – emergency services, preventive services, diagnostic tests, dental and vision care, substance abuse treatment, prescription drugs, acute and critical care, and long-term care – would all be covered. Virtually unlimited care with zero financial participation by patients regardless of their income makes this a fantasy. Too good to be true, overpromised and underfunded! We all know how that works.

A microscopic examination of the proposal reveals serious problems. What people need and what people are capable of demanding – a "free"



Arvind K. Goyal, M.D.

thing – are not one and the same. Free, discounted and sale merchandise always sells faster in our stores. People are willing to discuss rationing and limitations on health care in general terms. But when it comes to their own health, Americans usually insist on the best and the quickest. Given the current malpractice climate, it would be difficult for physicians to withhold advanced testing and technology and expensive medication. Health care costs could then spiral – maybe faster than the current rate.

Illinois taxpayers, businesses and citizens will pay more to fund the proposed program. The bill would more than double the state income tax and increase the employer payroll tax. While our large businesses already struggle from payday to payday, our small employers would take a real hit. Many businesses would be forced to close, causing unemployment to soar and exacerbating our worst fears.

It is ironic that solutions implemented by our government thus far have increased bureaucratic paperwork, bred inefficiency and failed to control costs. Some of these misguided policies have closed hospitals in areas of need and discouraged physicians' participation in governmental programs. Increasing and unrealistic governmental regulations have denied access to the very patients who need medical care the most. The government – which manages the Pentagon, Postal Service, immigration service, IRS, Medicare and Medicaid – should disqualify itself from taking on a bigger program. ▲

ARVIND

Arvind K. Goyal, M.D.  
President



## Guest Editorial

## A golden opportunity



by George T. Wilkins Jr., M.D.

How many of you opened your mailbox one day last February and experienced a cold blast of air in the form of one of U.S. Senate hopeful Al Hofeld's campaign brochures? It was a classic example of the weapons some candidates are using this election year to attack the medical profession and preserve the current medical malpractice litigation system.

If you did not have the pleasure of seeing this anti-doctor propaganda, let me briefly describe it for you. A soft lavender background surrounds a photograph of a beautiful young bride. A bold caption under the picture declares that her life was taken, but by what we don't know. Curious to know the facts, we open the brochure to find out that an "uncaring doctor" took her life. We are then reassured, however, that Al Hofeld – through his expert use of the litigation process – may help save our lives.

The mailer goes on to describe a really very tragic story of a late diagnosis of breast cancer, while it tactlessly showcases Al Hofeld's role as the family's attorney. Specifically, we learn that Al Hofeld told his clients that in this case – and in essentially every malpractice case – their family was not just battling for their daughter's right to compensation, but for everyone's right to proper medical care. Al Hofeld failed to mention his own compensation for this case, which according to a March 5 *Chicago Tribune* article, was \$750,000 to \$1 million of the \$3 million settlement.

Imagine the type of environment in which you and I would be forced to practice medicine if someone like Al Hofeld were elected to office. Because we would be at the mercy of elected officials who would go out of their way to promote malpractice litigation, we would be worrying even more about being sued than we do now. But the really bad news is that Al Hofeld is only the tip of the election iceberg. Many candidates this November are running on a "plaintiff attorney platform" that advocates a government-run, nationalized health care system. And they are using a tough, "take-no-prisoners" strategy to win votes.

The message couldn't be more clear. We are under siege in this year's election. Under siege by plaintiff attorneys who want to reverse

our hard-won medical malpractice reforms. Under siege by self-styled "consumer advocates" who think the solution to the nation's health care problems is a government-run, taxpayer-funded national health care system. And under siege by candidates supported by these groups who actually believe their arguments!

It's time to fight back – time to alter the composition of the lawyer-controlled judicial and legislative branches and elect our own representation. We need to elect legislators who understand the real problems facing today's patients and physicians. And because of Illinois' 10-year redistricting process, we have the opportunity to do so this fall.

"But how can I, just one doctor, influence the outcome?" you ask. By each and every one of us uniting and getting involved. Just as lawyers, unions, business and consumer groups bring their collective voices to Springfield, organized medicine must also. And our voice must be heard and our influence felt not only during the legislative session, but during the electoral process that determines who holds what office. This election year creates a golden opportunity for organized medicine to establish relationships and instill confidence in new legislators.

*We are under siege in  
this year's election.  
Under siege by  
plaintiff attorneys who  
want to reverse our  
hard-won medical  
malpractice reforms.*

One extremely effective way to influence the outcome of this year's elections is to join IMPAC, the Illinois State Medical Society Political Action Committee, which supports candidates who share medicine's views on health care. IMPAC support has frequently been the deciding factor in elections. We help put friends of medicine into office and help defeat elected officials who follow the directives of trial lawyers like Al Hofeld.

During this election year, IMPAC will work especially hard to ensure that proponents of organized medicine receive sufficient help to win their election campaigns. But we can't do it without you. I urge you to join the battle to preserve and enhance quality health care for our patients. I urge you to join IMPAC. The stakes have never been higher. ▲

*Dr. Wilkins is chairman of IMPAC, the Illinois State Medical Society Political Action Committee. To join IMPAC, or to receive more information, call (312) 782-1963.*



*Trial attorney and former U.S. Senate candidate Al Hofeld (left) circulated an anti-physician campaign brochure during the recent primary. In the brochure, Hofeld attacked the medical profession by implying that "uncaring" physicians are a root cause of the problems facing our health care delivery system. He also portrayed himself as a "fighter," not just for people's right to just compensation in medical malpractice cases, but "for everybody's right to proper medical care."*

## YOCON® YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

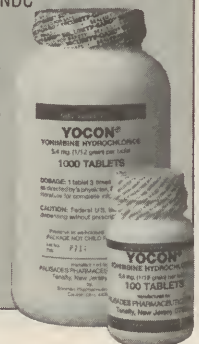
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

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## Exchange rewards good loss records

(continued from page 1)

announcement of the Exchange's new "loss-free" discount.

"I am pleased to announce the availability of an exciting new discount program from the Exchange," Dr. Jensen said. "It's called the loss-free discount. This program rewards physicians who have stayed with the Exchange and have excellent loss experience."

Policyholders will receive an initial 3 percent discount off the base premium for a no-payout record over the past three years. A 1 percent discount is applied for every additional year without a paid loss to a maximum available discount of 10 percent for 10 or more years of loss-free experience.

The loss-free discount follows the across-the-board dividends the Exchange paid to policyholders in 1990 and 1991.

### Clinic program offers group savings

"Another exciting discount program is the new Physician Clinic Program," Dr. Jensen said. "We have made some modifications to the Physician Clinic Program, originally implemented in 1988, in order to better serve the needs of Illinois physicians."

"First, we have changed the eligibility requirements so that many more physician groups have the opportunity to become part of the Physician Clinic Program," he continued. "Effective July 1, groups of



During the ISMS Annual Meeting April 10, Harold L. Jensen, M.D., chairman of the Exchange Board of Governors, announced policy improvements and discounts for 1992-93 to the House of Delegates.

five or more physicians are eligible for the program."

The new clinic program includes an up-front reduction and a further reduction based on favorable loss experience of the group after two years. Groups may select either a \$1 million or \$2 million limit for individual physicians or single suits or claims. The policy pays a maximum of three times that limit on behalf of all insureds for any one claim or suit. Aggregate coverage for clinics ranges from \$15 million to \$90 million, depending on staff size.

"The opportunity for clinics to

gain credits toward their premiums is one of the most exciting features of the clinic program," Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors, told *Illinois Medicine*. "Groups need to be confident, however, that they have a good loss experience and that it can be maintained," he said, explaining that the negative loss experience of one policyholder could counter the positive loss experience of others in the clinic.

A maximum premium credit of 28 percent is attainable with good loss experience and compliance with underwriting criteria, Dr. Boren said. However, a debit is also possible if the loss record is poor, he noted. Premium credits of up to 15 percent may be given through the scheduled rating process. After the policy's second renewal, experience ratings may result in premium credits or debits.

Slot rating, an alternative rating method that eliminates the need for tail coverage, is also available to groups with clinic coverage. With slot rating, the slot is insured rather than the physician.

"The elimination of the need for a physician or clinic to purchase tail coverage after a physician leaves a practice is the significant benefit of slot rating," Dr. Boren said. "Coverage will continue for all slot occupants at a constant limit until that slot is terminated, allowing physicians much more flexibility."

Dr. Jensen told the House that slot rating will be especially attractive to single-specialty groups.

## 1992 Exchange specialty rate reductions announced

• Gynecologists	13%
• ENTs	6% to 13%
• Anesthesiologists	8%
• General surgeons	6%
• Colon surgeons	6%
• Plastic surgeons	13%
• Hand surgeons	13%
• Urologists	8%
• Emergency physicians	8%
• Proctologists	8%
• Family physicians*	6%
• General practitioners*	6%
• Psychiatrists performing ECT	38%

\*Primarily performing major risk procedures.

### Some county, specialty rates decrease

"Due to good loss experience of physicians in DuPage, Kane, Lake and Vermilion counties, they are moving to the new, lower-rated Territory IA," said Dr. Jensen. "This move will result in a 10 percent savings for physicians in these counties."

Kankakee County physicians will move from Territory II to Territory III due to long-term favorable loss experience, resulting in a 31 percent savings.

"The Exchange salutes the 1,400 physicians in these counties who have improved their loss experience," Dr. Jensen said.

In addition to these premium reductions, more than 1,800 policyholders will move to a lower class effective July 1, Dr. Jensen said. This is due to a "continued downward trend in losses for several specialties," including anesthesiologists, urologists, proctologists, general surgeons, gynecologists, emergency physicians and ENTs who perform no elective cosmetic surgery. Other specialties will also see savings, with the biggest savings going to psychiatrists who perform electroconvulsive therapy. These physicians will see a 38 percent reduction in premiums for 1992-93.

Some loss trends will necessitate premium increases, especially in specialties where losses were higher than expected, Dr. Jensen said. "Unfortunately, our analysis revealed some specialties with higher than expected loss trends in comparison to other specialties in their classes," he said. "Because of this experience, it will be necessary to make some changes to assure that each policyholder pays a fair premium, and that our reserves remain sufficient to pay future losses."

### No increase in base premium

More good news for Exchange policyholders comes in the form of stable premium rates for 1992-93.

"Each year the Exchange conducts an in-depth analysis of the loss experience," Dr. Jensen said.

# AMIC

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## Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

**Q.** My hospital wants verification of my insurance coverage. How can I get this to them?

**A.** Verification is sent to a hospital or any third party (i.e., HMO, employer) in the form of a Certificate of Insurance. A Certificate of Insurance confirms to the third party your limits of liability and your policy effective date. Once the first Certificate of Insurance is issued, a new certificate is automatically issued each year upon renewal of your policy. We need your written request authorizing us to issue a Certificate of Insurance to a third party.

**Q.** I am a Class 2 physician and am covered for assisting in surgery. Does it make a difference if I assist in surgery on patients other than my own?

**A.** No. As a Class 2 physician you are covered to assist in surgery whether or not it is on your own patients.

**Q.** What is the statute of limitations with respect to a cause of action (lawsuit) being brought against me?

**A.** For adults, the statute of limitations is two years from the date of loss, or two years from the date of discovery, not to exceed a maximum of four years. The term "date of discovery" refers to the date the existence of some injury resulting from the treatment rendered is discovered.

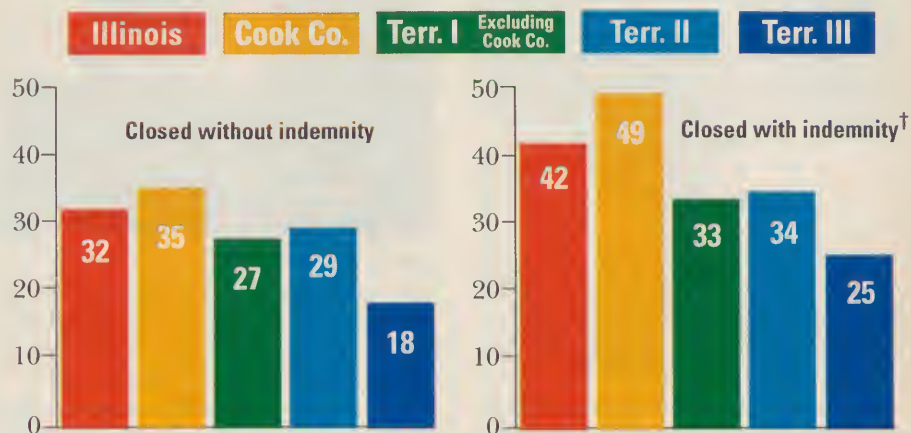
For minors, the statute of limitations is eight years from the date of loss up to age 18, but not to exceed the age of 22. (Example: a 17-year-old has five years to file a claim.)

It is important to note, however,



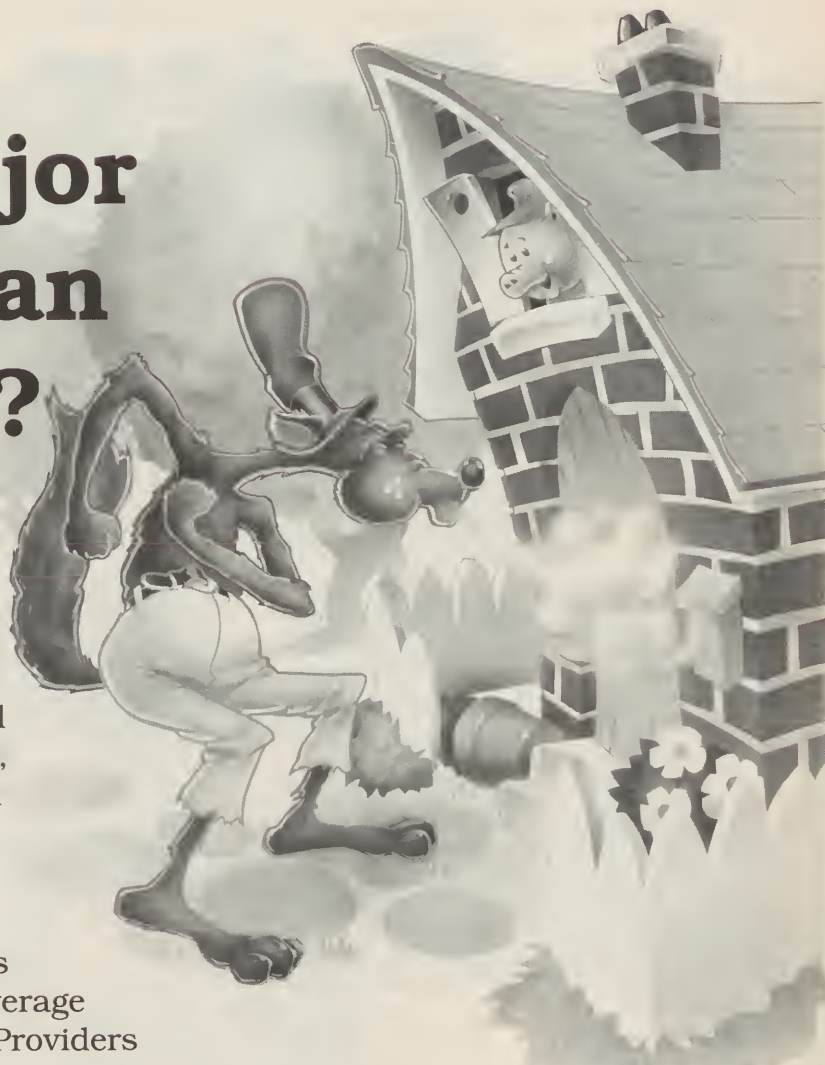
that a cause of action can be brought against you at any time. It is up to the legal process to determine the validity of the claim. ▲

### Average Exchange claim and suit life, since the Exchange's inception\* (in months)



\*July 1, 1976. †All claims/suits that were disposed of with a payment to the plaintiff.  
Source: Illinois State Medical Insurance Services, March 1992.

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### Exchange

(continued from previous page)

rience of the company," Dr. Jensen said. "As a result of this year's study, I am pleased to report that last year's base rate will be maintained for the 1992-93 policy year. This stability results from the efforts of Illinois physicians to reduce and prevent losses, and from the steady work of the Exchange in careful underwriting, aggressive claims handling and enhanced risk management activities."

Although there will be no increase in base premiums, claims-made coverage is priced so that premiums increase each year, to reflect increased exposure to liability, until a mature level is reached at the seventh year, he explained.

In closing, Dr. Jensen asked the delegation for input into the future of the Exchange. "We encourage you to share your thoughts," he said. "We need your comments and suggestions to continue making the Exchange responsive to the needs of Illinois physicians." ▲

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**New construction must comply**

New construction and facilities undergoing substantial alterations are subject to both the ADA and the Illinois Environmental Barriers Act, which has been in effect since 1985, says Lei Ann Marshall-Cohen, legal consultant to the National Center for Access Unlimited, a consulting firm specializing in ADA compliance issues.

"A newly constructed facility should be barrier-free," says Marshall-Cohen. "If an addition or alteration is planned, both the state law and the federal law kick in."

New construction that is available to the public after Jan. 26, 1993, will have to be in full compliance. Ac-



cording to the final regulations, issued July 26, 1991, a narrow exception is provided for facilities that can demonstrate that full compliance is "structurally impracticable."

But in those cases, compliance must still be to the maximum extent possible, and the exception will only

apply in rare circumstances where unique characteristics of terrain prevent compliance without destroying the physical integrity of the facility. In any case, for new construction cost considerations will not be a factor in determining the degree of compliance.

There is one other important point that at first appears to be a boon to physicians, but that proves illusory. An elevator exemption exists for buildings of less than three stories, or 3,000 square feet per floor or less. "But there's an exception to the exemption," according to attorney Donna J. Pugh, also of Katten Muchin & Zavis. "You don't get the elevator exemption if you are a provider of health care services, which is defined as someone who is regulated by the state."

Whether an otherwise exempted building has to have an elevator depends on its "intended use," adds Pugh. "If you've been marketing the facility as a medical office building, or it has special plumbing or something like that, even if no one is actually occupying it, the law says that it would have to have an elevator."

Slavitt adds that for physicians who may be looking at moving into such a building as a tenant, it is a good idea to make sure it complies with the elevator requirement.

**Alterations also subject to regulations**

Substantial alterations to a facility also qualify for compliance under the Act. The regulations define alterations as "a change to a place of public accommodation or a commercial facility that affects, or could affect, the usability of the facility." This includes remodeling, renovation, rehabilitation, reconstruction, historic restoration, changes or rearrangement in structural parts, or elements and changes or rearrangement in the plan configuration of walls and full-height partitions.

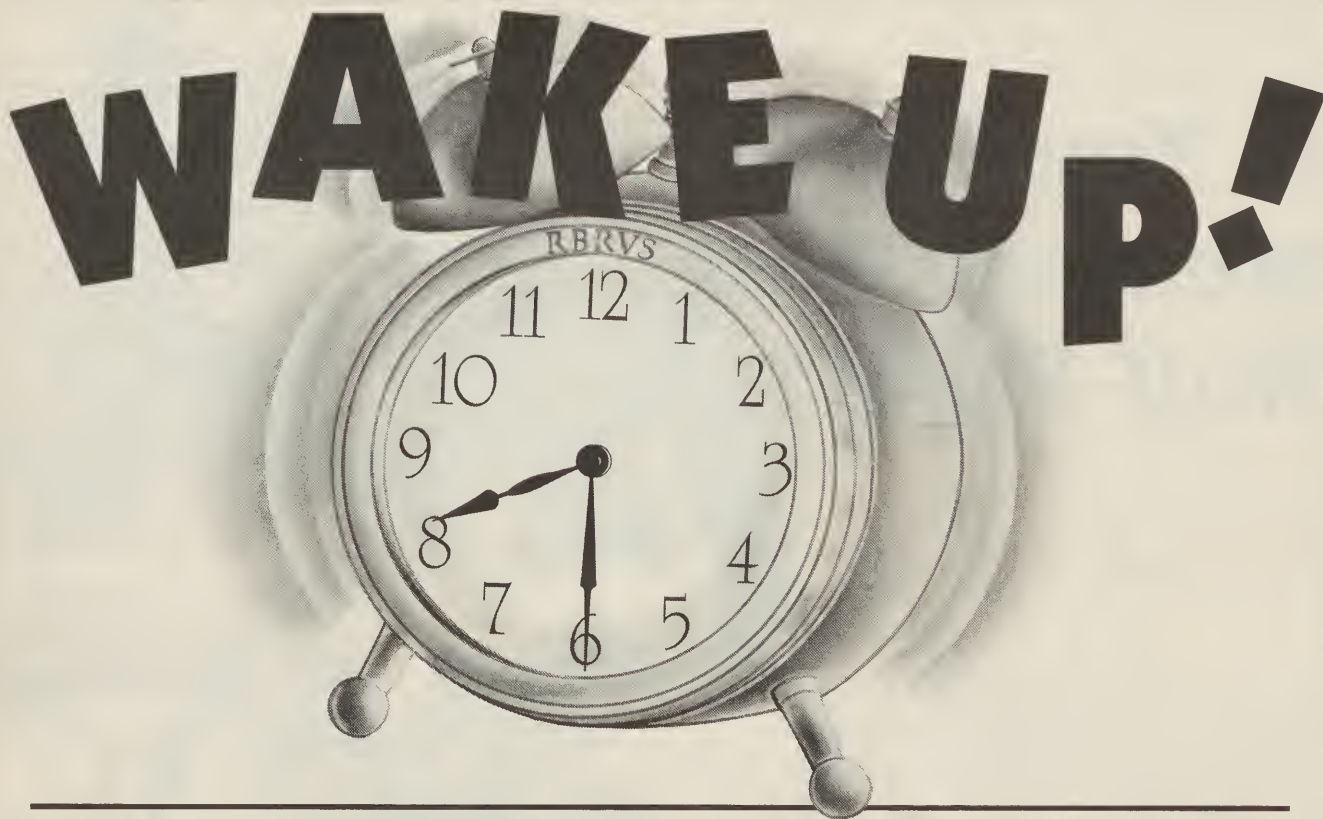
Alterations do not include normal maintenance, reroofing, painting or wallpapering, asbestos removal, or changes to mechanical or electrical systems unless these affect the usability of the structure.

One instance where physicians may be especially affected by the alteration provisions is if they alter their treatment rooms, which under the Act qualify as a "primary function area," Pugh adds.

"There's one additional obligation beyond that," she says. "If you're altering a primary function area, which is defined as the main area for which the facility is intended, ... you have to provide a 'path of travel,'" meaning that the route to the treating room also has to be in compliance.

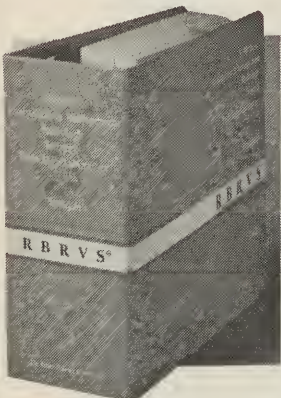
But, again, there is a narrow exception. "You have to provide a path of travel unless it is so exorbitant that the cost of providing the path of travel exceeds 20 percent of the cost of the actual alteration of the primary function area," says Pugh. "If it exceeds that, you don't have to do it, but you do have to do the maximum extent feasible."

The American Medical Association recommends that physicians contact several government offices for information on compliance with the Americans with Disabilities Act. Information on the public accommodations requirements is available from the U.S. Justice Department Office of ADA at (202) 514-0301. Information on the employment provisions can be obtained from the Equal Employment Opportunity Commission at (800) 669-3362. The Architectural and Transportation Barriers Compliance Board, a non-profit group, also publishes compliance guidelines for public accommodations. They can be reached at (800) USA-ABLE. ▲



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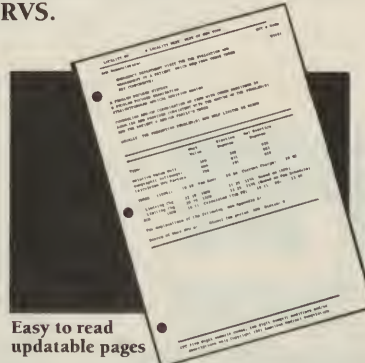
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*Next: Complying with the ADA for existing structures and who is responsible, the landlord or the tenant. Future articles on ADA compliance will address access to programs and services and employment issues.*



# Blue Cross profiles MDs for quality, cost control

by Anna Brown

THOUGH STILL IN its infant stages, Blue Cross and Blue Shield of Illinois' computerized physician profiling program is under way for 1992. The company says the proposal underscores its philosophy that quality in health care is "the issue of the '90s."

The company estimates that as much as \$250 million a year could be saved through eliminating unnecessary surgeries and encouraging better preventive care.

The Illinois State Medical Society House of Delegates April 12 adopted a resolution expressing "deep concern" about the program. The House asked Blue Cross and Blue Shield to shelve the program "pending further discussion with ISMS," and to urge the company "to share its findings with ISMS to be used in physician education." The House also reaffirmed its opposition to economic credentialing.

"The Illinois State Medical Society is for maintaining high-quality standards for medical care," said ISMS President Arvind K. Goyal, M.D. "However, we're concerned that unnecessary monitoring of physicians will become intrusive to the majority who are consistently providing high-quality care, and may not be cost-effective."

For the next 12 to 18 months, the Blues will launch the first phase of the physician monitoring system, beginning with primary care physicians, said Phil Lumpkin, director of health services. Eventually all 16,000 physicians in the Blues' managed care networks will be monitored.

"Our main objective at this point is understanding and clarifying data issues," Lumpkin said, explaining that since the program is new, no practice patterns have been determined yet. The patterns that are currently being studied in primary care offices include office visits, referrals and diagnostic patterns.

"We're on your side, we want to give you quality care," said Arnold Widen, M.D., Blue Cross medical director, to the physicians of Illinois. "We're working with professional societies to develop practice parameters and practice standards in conjunction with the medical community. The goal is to make utilization management more grounded in physician-approved standards."

Lumpkin concurred, adding that dialogues with Illinois physicians are just beginning. He explained that the program is intended to be "fairly flexible."

"We don't look at practice parameters as a way to constrict physician judgment," said Dr. Widen. "Whether we'd get to the point where we'd penalize or impose sanctions is another question. If practice behaviors are clearly not consistent with standards of practice, the care networks could deny those claims."

But such measures won't begin for at least a year, according to Lumpkin. "It will be fairly sequential, and fairly soon," he said, but the first matter at hand is to understand all of the data.

Physician profiling may not differ from normal utilization review in terms of time and hassle for physi-

cians, Lumpkin said. Interaction could be minimal if a physician has a good track record. Blue Cross is hoping these physicians might help hone the program.

"The program could become widely used as a means of sharing helpful and positive information that is beneficial for patients," Lumpkin said.

Dr. Widen said that physician incentives are a possibility for those physicians with the best utilization experience. "Interference with doctors is a waste of our time. I don't tell my colleagues that the hassle factor will go away, but we will impose [on physicians] fairly, and consistently with quality." Incentives would be based on cost savings, but would not

affect premiums, he said.

The Blues also plan to introduce random patient "tagging," which would follow a patient through an entire illness from diagnosis to recovery.


"Tagging could include following patients' medical records, or something less intensive," Lumpkin said. "An example could be following a cancer patient to try to understand what unfolds through claims. We need to learn what works and what doesn't."

"We want to know if patients are able to return to work as quickly as expected," said Dr. Widen. "And what about the most important quality issue: the quality of their lives?" ▲



Arnold Widen, M.D., Blue Cross medical director, says that while physician profiling may not reduce the "hassle factor," the program will be executed fairly.



  
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# Federal rules restrict physician lab ownership, referrals

by Tamara Strom

**JUST WHEN YOU** thought you understood the federal safe harbor regulations on your relationship with laboratories, the government issued additional rules governing how physicians can own and make referrals to labs.

Under the proposed rules, if a physician or a member of a doctor's family has a financial relationship with a laboratory, the physician may not refer patients to that lab if the testing services are to be covered by Medicare. The U.S. Health Care Financing Administration only regulates physician lab referrals of patients for whom the government foots the bill, such as those patients enrolled in the Medicare program.

In addition to limiting a physician's ability to refer patients to labs in which he or she has financial interest, the rules preclude the lab from submitting a Medicare claim for any tests if the doctor does in fact make such a prohibited referral. Regulated clinical lab services are included in the 80000 series of the *Current Procedural Terminology* codebook.

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*Physicians should curtail any questionable referrals of Medicare patients to labs they own or in which they have a financial stake.*

---

Although the provisions of the law went into effect Jan. 1, 1992, HCFA did not release the proposed rules until March 11 and is accepting comments until May 11. Despite the status of the rules, physicians should nonetheless curtail any questionable referrals of Medicare patients to labs they own or in which they have a financial stake.

Physicians who perform in-office lab testing for their own patients are not violating these rules. Physicians in group practices that offer lab services to the group's patients also are exempt from the rules. But the regulations do prohibit a consulting physician from referring a patient to a laboratory owned by the patient's primary physician. Doctors who perform lab tests also must adhere to other federal laws regulating their laboratories, such as the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

The rules also exempt laboratories in rural areas where availability of services is limited. The exemption holds as long as the majority of tests referred to rural laboratories are ordered by physicians who practice in a rural area.

According to the American Medical Association, about 10 percent of all physicians own at least partial interests in clinical laboratories. These physicians should seek legal advice to assure their investment in a clinical lab violates neither of these referral prohibitions. And because this rule operates independently of the

safe harbor regulations, physicians should continue to review their ownership, compensation and practice arrangements within the scope of each separate federal rule pertaining to lab referral.

## Steep penalties

Penalties for violating the rules are steep. HCFA is using the information obtained in the laboratory ownership surveys it sent to physicians last fall as the basis for determining which doctors hold financial interests in laboratories. Physicians who did not complete a survey in November must obtain one and submit it to

HCFA as soon as possible.

A physician billing for a prohibited referral is subject to civil monetary penalties of up to \$15,000 for each service billed. Also, physicians entering into financial agreements with laboratories where investment returns are based on the number of referrals made will be fined up to \$100,000 for each agreement.

In addition, all Medicare Part B claims submitted for reimbursement of lab services must include the name and provider number of the referring physician. Claims submitted without this information will be denied. However, if the lab knowingly leaves the referring doctor's name

off the claim because of the physician's vested interest in the lab, HCFA has the authority to levy civil monetary penalties up to \$2,000. Repeat offenses could result in the facility being excluded from participating in all federal health programs for up to five years.

The rule also applies to sales of clinical labs that are not yet complete. If a doctor sold a lab before Jan. 1, 1992, for a set price with installment payments still being made by the buyer, the selling physician is prohibited from making referrals to that laboratory until all payments have been made. ▲



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## Budget cuts

(continued from page 2)

pating physician, a Medicaid partnership network, a federally qualified health center or an HMO. The patients' primary care provider will provide all routine health services and arrange for any needed specialty care.

Edgar's Healthy Moms, Healthy Kids initiative calls for doctors participating in the program to receive rate increases for primary care plus a monthly managed care per capita fee. In addition, physicians providing preventive and prenatal services will be paid monthly to assure a "constant stream of income," according to the Illinois Department of Public Aid.

Downstate, the governor is recommending an increase in social case management services through local health departments and schools, creating physician referral networks to ease patient access, establishing minimum qualification requirements for participating physicians, and raising reimbursement rates for doctors who provide more service and offer 24-hour availability. \$13.2 million of the

funding for this program will go to physicians around the state for increased rates and capitation payments.

He also called on the lawmakers to enact the necessary legislation to keep Illinois' new provider assessment program legal within federal guidelines. Without the mandated changes in the law, the assessment program will become illegal after Sept. 30. In addition, Edgar proposed a hike in provider contributions to the assessment program. The program returns more than \$600 million in federal dollars to the state Medicaid program.

### IDPH loses dollars, keeps prevention priorities

Although forced to absorb an 11.5 percent – or \$12 million – slash in general revenue funding in Edgar's fiscal 1993 budget, the Illinois Department of Public Health will retain funding for its priority programs, according to IDPH spokesman Tom Schafer.

"The key areas we fought for and that the governor agreed were hands-off for cuts were infant mortality and AIDS," Schafer said. "We kept

our priority prevention programs."

Not only did the state's infant mortality program retain its current funding level, but Illinois will receive an additional \$4 million in federal funds for the Healthy Start program as part of President Bush's healthy preschooler initiative announced last year. "We can continue to work against the tragedy of infant mortality by making sure pregnant women receive the counseling, nutritional aid and medical attention necessary to prevent young babies from dying unnecessarily," Edgar said.

The IDPH AIDS program was one of very few programs to receive an actual increase in general revenue funding this year, Schafer said. The overall AIDS line grew by \$300,000 in Edgar's budget, from \$3.6 million last year to \$3.9 million for the coming year. This funding hike includes \$500,000 for implementation of S.B. 999, the compromise HIV notification law passed at the end of last year's legislative session. About \$200,000 in AIDS education funding was cut to allow IDPH to cover the cost of the S.B. 999 provisions as estimated by lawmakers when the bill was passed.

The Department of Mental Health and Developmental Disabilities also will receive modest funding increases this year. The governor said much of this money is earmarked for expanding community-based mental health facilities and bolstering efforts to "aid people who have disabilities in achieving independent lives and in developing skills for employment."

Lawmakers will debate Edgar's budget plan during the upcoming legislative session. If they disagree with his proposals, they must propose alternatives that achieve the same bottom line – a balanced budget. Edgar vowed he would not sign a budget in which spending is out of line with the state's sagging revenues.

In a related matter, Edgar shifted \$100 million into the state's ailing health plan for employees. The underfunded employee health program needed the funds in order to continue paying medical bills for state workers. Although the infusion of funds will not speed up the payment cycle, it will cover many provider bills already submitted. ▲

## Belleville medical community

(continued from page 1)

Elizabeth's Hospital in Belleville in April 1991. Although no malpractice suit has been filed, the plaintiff's attorney, Bruce Cook, deposed Dr. Vest under a little-used state Supreme Court rule, the interpretation of which is at the root of the matter.

Montroy and Dr. Vest claim that Cook went beyond the reasonable line of questioning under the rule, which they interpret to be solely a means for the plaintiff to discover the names and addresses of individuals who may have knowledge pertaining to a potential claim.

"Cook had tried to obtain information over and beyond that," Montroy

said. "He tried to get opinion questions from Dr. Vest regarding the patient's treatment."

In all, 17 physicians treated Roth. William W. Sprich, M.D., St. Clair County Medical Society president, believes that Cook intends to depose all of them before filing a suit.

Both Montroy and Dr. Vest contend that without filing a lawsuit, a deposition on the subject of treatment was unfair, and that Dr. Vest was treated like a defendant by Cook. Cook claimed he was unable to obtain a required certificate of merit in order to file a suit, and therefore sought to gain information on whether to pursue a suit by deposing Dr. Vest.

"Dr. Vest owes a duty to his patients of full disclosure, period," Cook said. "He refused to answer the

question because he wants to be a sacrificial lamb, because [his attorneys] told him it was a good idea."

Dr. Vest said he spent an hour and a half with Roth's family after his death discussing the situation.

"In no way does the medical society or Dr. Vest want to impede the right of the family to bring up any questions about their loved one," Dr. Sprich said. "It is the family's right to seek a lawsuit. In no way do we want to impede a lawsuit."

"The problem is," he continued, "this law hasn't been tested. We are waiting for an opinion [from the appellate court]. Given the inflammatory nature of the case, I believe it will be heard by the [Illinois] Supreme Court no matter what. If it is decided the other way it will have repercussions for the entire state."

### Underlying politics

Another factor in the case, according to Dr. Vest, his attorney and community physicians, is Cook's and other plaintiffs' attorneys high degree of influence in St. Clair County politics. Dr. Vest also claimed that Judge Radcliffe is a former law partner of Cook's.

"In general, disputes of legal interpretation are handled in a professional manner anywhere else in Illinois," Dr. Welch said. "However, some judges are plaintiff-oriented, and this is magnified in St. Clair County."

"In cases like this, it's the patient who suffers, not the doctor or the attorney," he said.

Dr. Vest said he had to cancel 35 patient appointments as a result of his incarceration.

"A judge has every right to jail someone for contempt, but it is beyond reason to throw a busy physician in jail for acting under the advice of counsel," Dr. Welch continued. "If upheld, this ruling will take several steps backward for all of tort law."

Dr. Welch further explained that unless the rule is detailed, it represents "a way to get around rules for the protection of rights."

Dr. Vest said Cook's initial questions were very basic, regarding names and dates. The questions soon became more specific, until Cook asked if Dr. Vest had attempted to take a test that would culture out a bacterial infection. At this point, Dr. Vest said he refused to answer.

"The deposition was well-orchestrated," Dr. Vest said. "[Roth's] family was there, and Cook got a judge who would rule in his favor. In my own mind, I thought it would come to this, that I would go to jail. I don't mind a fair fight, but when both hands are tied, it's hard to win." ▲

## Political scene

(continued from page 3)

election year. Nonetheless, physician input into the political process is more important than ever this year, said incoming IMPAC Chairman George T. Wilkins Jr., M.D. "Physicians should initiate contact with legislators and candidates now to begin establishing relationships," he said. "If these candidates are elected or re-elected to the General Assembly in the fall, they will be more inclined to listen to their physician constituents in the future. Just a few contacts from doctors in a district does more to catch a lawmaker's attention than hours of lobbying."

Dr. Jensen added personal contact with legislators is necessary above and beyond contributing money to individual campaigns or to IMPAC. "Doctors can't just vote and contribute," he noted. "Talking with legislators about medicine's concerns is critical. IMPAC isn't a PAC for doctors. It's for patients. Much of our role in the legislative arena is that of patient advocates."

Dr. Wilkins noted that IMPAC contributes to key targeted races for candidates in both political parties. "We need friends on both sides of the aisle to help assure that only responsible health care legislation that benefits our patients is advanced." ▲

## Physicians must use HCFA 1500 form for Medicare claims

by Tamara Strom

EFFORTS TO save the "superbill" from the federal government's intent to abolish it have failed. Effective May 1, physicians must use only the U.S. Health Care Financing Administration's Medicare 1500 form to submit Part B claims.

HCFA announced the ban on superbills and other similar attachments in November, citing administrative burdens and rising costs. Although organized medicine supports the concept of a universal claim form such as the 1500, many groups, including the Illinois State Medical Society, asked the agency to allow physicians to continue superbill use. The government said up to 10 percent of all Medicare Part B paper claims are submitted with attachments.

The agency had planned to stop accepting superbills April 1, but in response to comments from the medical community gave the nation's physicians a one-month grace period until May 1. On that date, physicians must begin including the information they would have put on a superbill in the corresponding spaces on the 1500 form. HCFA will now accept only those attachments that provide medical evidence, certify medical necessity or are required by law. Any claims submitted using a superbill will be returned. Physicians may circumvent the 1500 form by using an electronic claims processing system to submit Medicare Part B claims.

Physicians using claim forms, however, must use original forms that include all necessary information. Photocopies probably will not be acceptable. Doctors may obtain claim forms from either the American Medical Association or the U.S. Government Printing Office. ▲



## House of Delegates

(continued from page 1)

Medical Association.

On Sunday morning, Arvind K. Goyal, M.D., a family physician from Rolling Meadows, took the oath of office as the Society's 1992 president from outgoing President Robert M. Reardon, M.D., a Bloomington ophthalmologist. Also on Sunday, Jere E. Freidheim, M.D., of Burr Ridge was elected chairman of the Board of Trustees.

The Society's public service honors went to James P. Monahan, M.D., of Wadsworth, and the Winnebago County Medical Society Auxiliary during Saturday's session of the House of Delegates.

The House of Delegates approved a Board of Trustees-sponsored resolution changing the Society's bylaws to limit officer and trustee terms of office. The resolution was in response to a 1991 effort to implement term limitation. At that time, ISMS Chairman George T. Wilkins Jr., M.D., pledged to the House of Delegates that the board would study the issue and report back in 1992.

Effective July 1, the president-elect and vice presidents will be limited to one one-year term, with a lifetime eligibility of one full term for each of-

fice. The secretary-treasurer, speaker of the House and vice speaker of the House will be able to serve a maximum of two one-year terms each. With the exception of the speaker and vice speaker, who previously could serve only two consecutive one-year terms each, there had been no limits on the number of terms officers could serve.

District trustees are now limited to three consecutive three-year terms, with a lifetime maximum of 12 years' service. The resolution originally provided for 15 years' maximum service, but the House accepted the reference committee's recommendation to shorten the maximum years a trustee could serve. Previously, district trustees were limited to three consecutive three-year terms but were not subject to a maximum lifetime service. While the new rules take effect July 1, district trustees already seated on that date will be allowed to complete their full terms.

ISMS also adopted a policy governing conflict of interest for physicians serving in ISMS leadership positions. Physicians serving in elected positions, or on an ISMS council or committee, will henceforth be required to disclose any "direct or indirect interest, financial or otherwise, in the outcome of any transaction or matter involving the Society."

## House adopts principles for health care reform

The House adopted principles for health care reform rejecting the concept of a single-payer national health care system. Instead, the principles support reform of the health insurance industry to assure that all individuals receive basic coverage despite any pre-existing conditions. In addition, employers should be responsible for ensuring that employees and their dependents have private health insurance or access to the system through modified versions of the current government-run system. Also, the report advocated deductibles and patient co-payments to help make consumers conscious of the cost of health care.

The Society also reaffirmed its long-held support for reform of the tort system through establishment of caps on non-economic damages in medical malpractice cases.

## Public health issues addressed

Several public health matters also received the delegates' attention. At the direction of the House, ISMS will cause legislation to be introduced seeking to regulate tattoo parlors. This regulation is to include registration with the Illinois Department of Public Health, regular state inspec-

tions, licensing for the performance of tattooing procedures and requiring that tattoo parlor operators obtain informed consent from patrons. ISMS will also seek passage of legislation to license and regulate electrolysis practitioners and facilities.

Gun control and firearm safety resolutions also met with the delegates' approval. Again, the House directed that legislation be introduced in the General Assembly for the registration of all guns in the state and the licensing of handguns, as well as mandating locked storage of guns in homes with children. ISMS will encourage establishment of extensive education programs about gun safety.

The House reaffirmed its support for mandating helmets for motorcycle riders and excluding physicians from participating in state executions of prisoners. The 1991 House of Delegates declared any participation unethical, and the AMA House of Delegates followed suit in June. Current Illinois law requires a physician to witness a state execution for the purpose of pronouncing death.

Comprehensive coverage of the 1992 House of Delegates annual meeting will appear in the next issue of *Illinois Medicine*. ▲

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**Medical director – Centralia Correctional Center in Centralia** is searching for a medical director candidate to help run the medical facility at this medium-security institution. This position offers a good mix of clinical and administrative duties, without the burden of the overhead of private practice. Compensation is extremely competitive and the position is open immediately. For more information contact John Bogdan, Correctional Medical Systems, 999 Executive Parkway, St. Louis, MO 63141, or call (800) 325-4809, ext. 3107.

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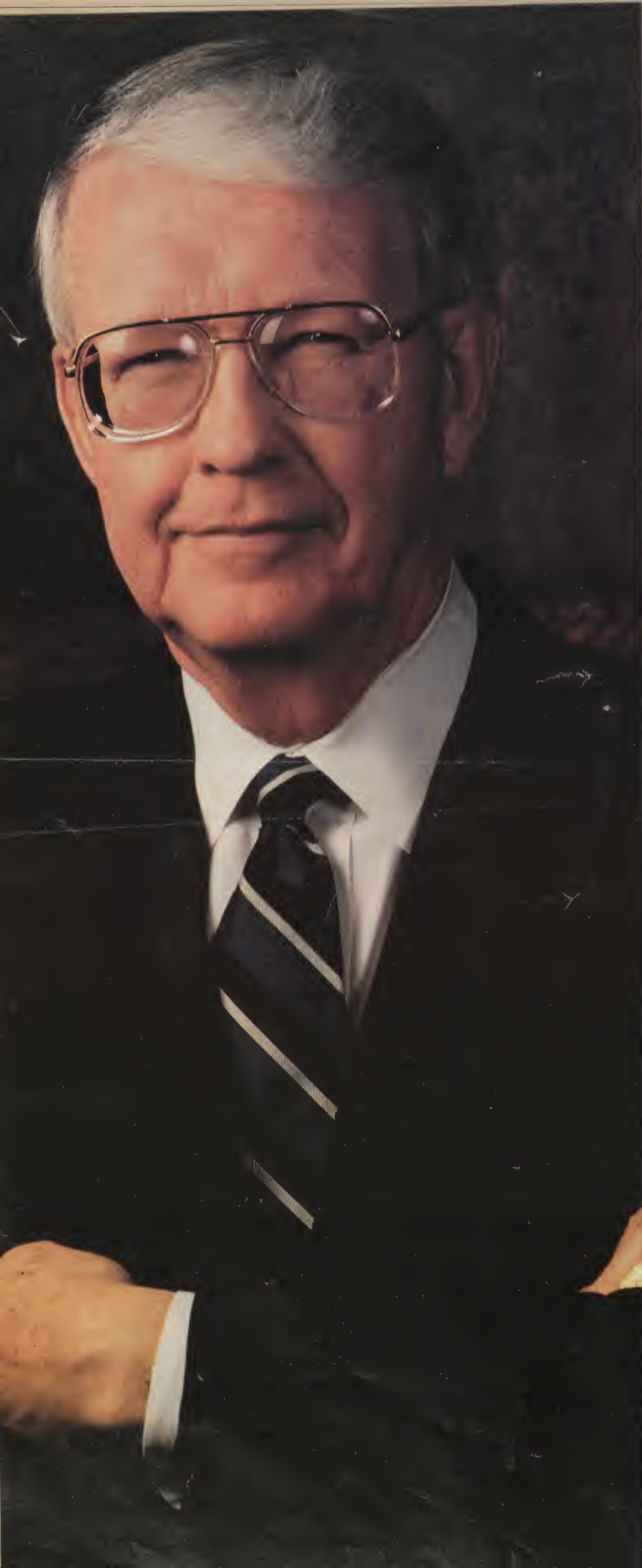
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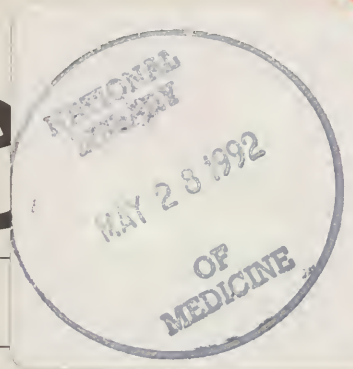
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May 8, 1992

ILLINOIS STATE MEDICAL SOCIETY

## Universal health bills advance

by Tamara Strom

MINUS A \$54 billion price tag, House and Senate bills creating a single-payer, government-run health care system for Illinois moved closer to floor debate and vote last week.

H.B. 2774 was voted out of the House Health Care Committee April 29 by a vote of 11-8, the minimum needed for passage. The Senate Public Health, Welfare and Corrections Committee passed its version, S.B. 1495, 7-6 on April 30. May 1 was the deadline for bills to be considered during the current legislative session.

The bills establish a blue ribbon panel to develop funding for the program, still scheduled for implementation on Jan. 1, 1995. Funding for the system was amended out April 22 by

	1990	1991
HB 2774	31%	31%
SB 1495	26%	26%
Million \$	\$ 7,951	\$ 8,661
%	5.7	5.7
Million \$	\$ 4,938	\$ 4,938
%	14.5	14.5
NA	NA	NA
NA	NA	NA
NA	NA	NA

	Without	With HB
Million \$	\$ 7,929	\$ 14.5
%	14.5	14.5
NA	NA	NA
NA	NA	NA
NA	NA	NA
NA	NA	NA
NA	NA	NA

ISMS President Arvind K. Goyal, M.D., (left) testifies before a joint House-Senate committee hearing on proposed legislation to create a single-payer, government-run health care system for Illinois.

House sponsor Rep. Anthony L. Young (D-Chicago) after more than four hours of testimony during a joint House-Senate committee hearing. The amendment was also attached to the Senate version.

Much of the testimony from bill opponents, including the Illinois State Medical Society, centered on the high cost of implementing the system. Presenting the legislation without funding  
(continued on page 21)

## ISMS House of Delegates debates issues, elects officers

by Kevin O'Brien

THE ILLINOIS State Medical Society's House of Delegates acted on 91 resolutions; elected new officers, trustees and delegates to the 1993-94 meetings of the American Medical Association; and recognized outstanding contributions by physicians and others at its 1992 annual meeting April 10-12.

Convening the House in Oak Brook, Raymond E. Hoffmann, M.D., speaker of the House of Delegates, gavelled the meeting to order at 9:30 a.m. on Friday. Five reference committees heard testimony from delegates and ISMS members on Friday afternoon.

The annual President's Night dinner honoring Robert M. Reardon, M.D., a Bloomington ophthalmologist, was held Friday evening. Entertainment was provided by Limited Edition, a jazz vocal group from Illinois Wesleyan University's School of Music under the direction of Prof. Barrington Coleman. The John Hunt Orchestra provided music for dinner and dancing.

Delegates and their spouses gathered early Saturday morning for the annual Public Affairs Breakfast, with featured speaker Republican U.S. Senate candidate Richard S. Williamson. Williamson, who served in the administrations of Presidents Reagan and Bush, faces Cook County Recorder of Deeds Carol Moseley Braun in the November general election for the Senate seat of Democrat incumbent Alan J. Dixon.

On Sunday morning, delegates installed Arvind K. Goyal, M.D., a family physician from Rolling Meadows, as its 1992-93 president, succeeding Dr. Reardon. Also on Sunday, the ISMS Board of Trustees elected Jere E. Freidheim, M.D., a pediatrician from Burr Ridge, its chairman, succeeding George T. Wilkins Jr., M.D., of Edwardsville.

The Society's public service honors went to James P. Monahan, M.D., of Wadsworth, and the Winnebago County Medical Society Auxiliary. The weekend also featured the Society's annual Fifty Year Club Luncheon, an educational seminar on health care reform in the United States, and the Illinois State Medical Society Political Action Committee's (IMPAC) annual meeting. In addition, the ISMS Auxiliary held its annual meeting April 8-10. ▲



'Partners' program wins AARP Award: On behalf of the Illinois State Medical Society, Jane L. Jackman, M.D., accepts a "Partners-in-Eldercare Award" from Bill Westerberg, state director of the American Association of Retired Persons, at the Illinois Business Labor and Aging Seminar April 23 in Springfield. The Society's "Partners for Health" program was honored for its contribution to the lives and health care of Illinois seniors. ▲

## Payments still slow Funds boost state workers health plan

by Tamara Strom

EVEN THOUGH Gov. Jim Edgar and the Illinois General Assembly approved a \$100 million bailout of the state employees health insurance program, physicians who treat these patients will not see reimbursement checks any faster. Officials of the Department of Central Management Services, which administers the health plan, said the supplemental appropriation will help make ends meet, but because the funds infusion will occur over time, it will not speed up the payment cycle.

"A lot of the appropriation will come from special funds and general revenue funds, so the money will come to us sporadically as it becomes available," said Mark Schmidt, DCMS  
(continued on page 3)



Left, an ISMS delegate takes time out from the annual meeting to catch up on Illinois Medicine. Coverage of the meeting begins on page 8. ▲

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# Floods soak physicians' practices

by Rachel Brown

KATHERINE WIER, M.D., returned from a vacation to find her practice crippled by floodwaters. Dr. Wier's dermatology practice, located at 25 E. Washington St., has been closed since April 13, when millions of gallons of Chicago River water flooded Loop basements. With no access to her office and patients, Dr. Wier has been forced to communicate by public and cellular phones.

"Basically, this has turned into a practice by phone," said Dr. Wier, who returned patients' calls by spending two rolls of quarters and three to four hours on pay phones. "My wrist gave out," she said, recalling the day after her marathon phone sessions. "It just wouldn't move anymore."

Murray Pelta, M.D., an obstetrician/gynecologist in the Loop, was also without phone service for a

week and was forced to use pagers and public phones.

Although Dr. Pelta had all calls forwarded to his phone service and worked with a beeper, to make outgoing calls he had to "run downstairs to the phone booth."

"It was really inconvenient," said Dr. Pelta, whose office is on the 20th floor at 111 N. Wabash. "I kept getting beeped every two minutes."

The generosity of area businesses and physicians helped Dr. Wier continue her practice despite the unusual disruption.

Dr. Wier and her secretary used a desk at the Michigan Avenue National Bank for an hour to sort through the week's mail. Dr. Wier also has been allowed to check her microscope slides at Northwestern University Medical School's Department of Dermatology, and will spend Thursdays and Saturdays "borrowing" the offices of a Loop physician to see patients.



Wm. Daniels/The Photo Partners

Left: Displaced because of floodwaters, Elizabeth Wier, M.D., was forced to move her practice – and her paperwork – to another physician's office nearby.

Right: Without phone service for one week, Murray Pelta, M.D., had to use beepers and pay phones to keep in touch with patients.

Despite the inconvenience of the Great Chicago Flood, Dr. Pelta is thankful his practice was only minimally affected by the water. "We were upset, but it could have been a lot worse," he said.

Dr. Wier, who is uncertain when

her practice will be up and running again, says that despite the inconvenience for Loop physicians, it is important for affected doctors "to be available and able to take care of our patients." ▲

## Chicago health department takes flood recovery action

by Anna Brown

THE CHICAGO Department of Health swung into action, inspecting restaurants and food stands and administering tetanus shots in the days following the flood in Chicago's underground freight tunnels, according to John Wilhelm, M.D., CDOH's director of the Bureau of Public Health. Dr. Wilhelm said the actions taken by the department were similar to those taken during Chicago's

West Side blackout during the summer of 1990.

About 1,000 food businesses were affected by floodwaters or power outages, Dr. Wilhelm said. By April 23, 10 days after the flooding began, CDOH had inspected 975 of them. "Most were fine, but a few had to close," he said.

The department worked in teams with the Department of Water and the Department of Environment, inspecting everything from food to

drinking water to the types of cleaning solutions used as floodwaters subsided. CDOH's main function, however, was to make sure spoiled food was discarded by establishments that lost power.

"Restaurant owners are used to seeing us, so it's not much different," he said about the inspections. "It's important for the public to see us to allay their fears. We're trying to dispel any doubt about contamination. So far, we've seen no food-related outbreaks since the flood began."

The department also administered "well over 1,000" tetanus booster shots to flood workers and "anyone who even saw floodwater," Dr. Wilhelm said. Public tetanus immunization was available every day after April 16, except Easter Sunday, until April 24; Chicago businesses may schedule additional boosters through the department.

"All adults should be boosted every 10 years," Dr. Wilhelm said. "We had a tremendous response. We had requests to go to pumping stations, and made several trips to the work site at the Kinzie Street bridge."

"If we could only get this kind of attention for measles immunization for preschool children we'd be in much better shape," he continued.

Many people were concerned about the health risks involved in cleaning up buildings affected by the flood. Dr. Wilhelm said that while some bacteria and mold were found in standing water, it posed less hazard if common sense precautions were taken, such as gloves for workers and hand washing.

"The flood gave us the opportunity to remind people about hygiene," he said, noting that while flood-damaged buildings are not yet complete-



Wm. Daniels/The Photo Partners

Fred Bermiester, a carpenter at the Pittsfield Building, 55 E. Washington, points to the spot to which floodwaters rose. The building, which houses 110 physicians and their practices, was one of the worst hit by the subterranean floods.

ly sanitary, no buildings are ever sterile. Dr. Wilhelm said the floodwater is from a river designated as Class 2 recreational water, safe enough for boating and swimming. "As [water] stands, bacteria multiply, and when it drains it smells," he said, but the smell goes away with cleaning.

In addition to these efforts, CDOH has asked flood contractors to monitor their workers and report such symptoms as fever or diarrhea. "This is a built-in surveillance system for us," Dr. Wilhelm said. "Otherwise we have to wait for a worker to see a doctor, and the doctor to report to us."

The Illinois Department of Public Health took a "primarily advisory role" during the days after the flood, said spokesman Judy Plazyk. Director John R. Lumpkin, M.D., notified the city that workers were available, she said. Plazyk commended the CDOH's efforts, which made any further action by IDPH unnecessary. ▲

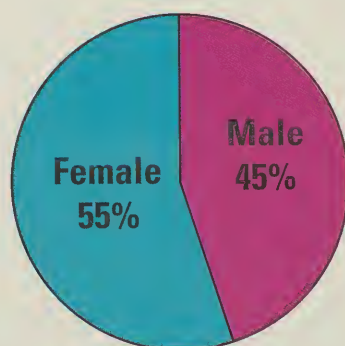
## Physician Facts

### Diabetes-related deaths in Illinois

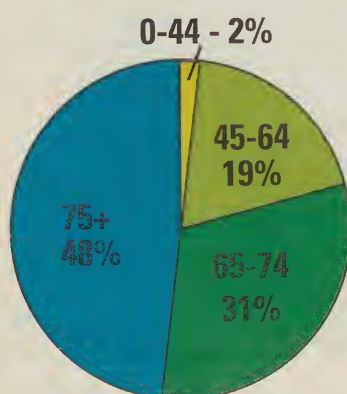
In the United States, about 14 million people have diabetes, of which about 7 million (about 3 percent of the U.S. population) have been diagnosed. The disease killed or was an underlying cause in the deaths of 8,076 Illinoisans in 1990.

May is Diabetes Education Month. Following are some Illinois diabetes mortality statistics by sex, age and race.

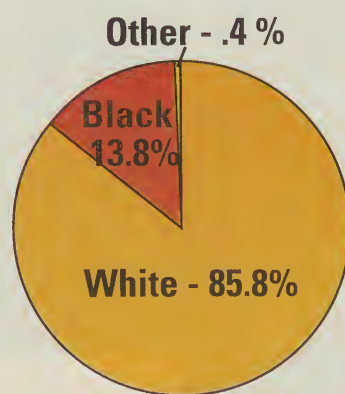
#### Sex



#### Age



#### Race



Source: *Diabetes in the United States: A Strategy for Prevention*; and *Diabetes Fact Sheet, 1990*, both published by the U.S. Centers For Disease Control, Atlanta.

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## State workers health plan

(continued from page 1)

spokesman. "It's not coming in all at one time; it will reach us in bits and pieces. If there is a perception out there that the payment cycle is speeding up significantly because the governor and the General Assembly approved this transfer of \$100 million, that's not accurate. But [the money] will come in sufficient time to allow us to continue paying claims on the current schedule for the rest of the fiscal year."

April is a "big revenue month" for the state because of income tax filings, Schmidt said, and the department did receive enough money during the week of April 13 to release almost \$12.5 million in claims for payment. Schmidt said DCMS had paid claims submitted through Feb. 28 for PPO hospitals. Claims submitted with unassigned benefits – the employees themselves are awaiting reimbursement – are paid through Feb. 21. The category of providers into which most physicians fit – assigned non-PPO providers – is paid only through Jan. 11. "For non-PPO hospitals and physicians, I suspect we'll stay at the 90- to 100-day range through the end of the fiscal year," Schmidt said.

"Our expectation is that the supplemental appropriation will allow us to keep the present payment cycle, although we'll still be roughly \$50 million short at the end of the fiscal year, which is about a month of operating expenses," Schmidt said.

Physicians who treat state workers are taking news of the funds transfer cautiously. "Overall, this is very good news," said Jane L. Jackman, M.D., Illinois State Medical Society Fifth District trustee. "It certainly is something we welcome, but we wish they could do more. We're encouraged that they appropriated this money, but we wish they could do something to speed up the payment cycle."

Springfield-area primary care physicians have been particularly hard hit by the payment slowdown, she said, explaining that overhead and operating costs, such as payroll, put a financial drain on physicians who are not getting paid. "Physicians have huge expenses each month just to keep the practice open," Dr. Jackman said. "Most doctors don't have that large of an amount of money on hand. They count on their monthly payment from insurance companies to pay those costs."

Adding to the problem, the Illinois Department of Public Aid has been able to make only small inroads toward speeding up its payment cycle, Dr. Jackman said. "If you are a physician who has a combination of public aid [patients] and state employees, that gets really hard," she added. "I really think some doctors in Springfield will have to take out bank loans soon to cover expenses."

Despite the gloomy financial picture painted by the analysis of payment cycles, Dr. Jackman said most area doctors are "patient and understanding" with their patients. But while doctors are "being patient" about slow reimbursements, "I think you'd have people marching on the Capitol if the payment cycle would drag out much longer," she noted.

To cope, many physicians are requesting partial payment from patients at the time of service, she said, but added that she doesn't believe

state employees are being singled out. "These are good patients who don't give you a lot of problems," she said. "But obviously you can't wait six months for every payment. Many physicians are working out payment plans with their patients."

Dr. Jackman said she is disappointed the plan will end the fiscal year \$50 million in the red, because that deficit will have to be tacked on to next year's expenses without a guarantee that funding will be appropriated to cover it. DCMS said the governor recommended full funding of the employee health program in his proposed fiscal 1993 budget. "If the General Assembly approves the governor's budget request to fully fund the program in 1993," Schmidt said, "Then you'll see [the payment cycle] start catching up." ▲

## State requests MRI surveys

PHYSICIANS who have purchased magnetic resonance imaging equipment are being urged to complete and return a survey from the Illinois Health Facilities Planning Board. The board's survey requests information on the operation and ownership of MRI equipment. The board has requested that the surveys be returned **immediately**.

The survey information will be used to help legislators make informed decisions about physician office regulation, according to IHFPB staff. Questions about the survey should be directed to Phil Garner at (217) 782-3516. ▲

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## REPORT FOR *Illinois Physicians*

### A Blue Shield Guide for Completing the HCFA 1500 Form

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#### Place of Service Codes

As a reminder, Blue Shield is not currently accepting the new two-digit Place of Service (POS) codes required by Medicare. Please continue to use the one-digit POS codes until further notice by Blue Shield.

#### Secondary Claims

At this time, BCBSI does not accept secondary Blue Shield claims submitted electronically.

Claims which automatically crossover from Medicare B to Blue Shield (as indicated on the Medicare B Explanation of Benefits) have been submitted for you.

All other Blue Shield secondary claims must have the EOMB attached to the paper claim form.

Please call the Hospital and Professional Affairs Department at (312) 938-7073 if you would like to receive the most current listing of the crossover Blue Shield supplemental groups.

#### Special Clinical Psychiatric Diagnostic or Evaluative Procedures

As a reminder, claims for these procedures can be submitted electronically. Operative reports are not required. When submitting such charges, please ensure to include the time, in hours, in the UNITS field (Item 24 in the HCFA 1500).

#### Provider/Submitter Claim Status (PSCS) Update

Your office staff is encouraged to note that Medicare B claims, when submitted electronically, will be displayed on the PSCS "Submitted" screen for up to 14 days.

(This report is published as a service to the physicians of Illinois.)

(5/8/92)



## Editorial

## It's your turn, again

**P**hysicians of Illinois, fair warning: You are about to take another broadside hit.

Unless they change their plans – and that's unlikely – members and supporters of the Campaign for Better Health Care, a group of self-styled consumer action organizations, will travel to Springfield May 13 to directly attack you.

According to a flyer promoting the event, CBHC has scheduled a Health Care Action Day this Wednesday from 11 a.m. to 3:30 p.m. The group plans a rally at the ISMS Springfield office, after which they will march to the Statehouse to meet with legislators. And they make no bones about their target. Right there in boldface type they say so: "12:30 p.m. – Rally to Protest the State Medical Society."

Proclaiming health care "a right – not a privilege," the flyer says that ISMS has blocked "any meaningful health care reforms to expand access to care or control costs," and announces that, "It is time that Illinois consumers expose these special interests for what they are, and demand that our elected officials support the people."

That's *you* they're talking about when they say "special interests." Specifically, CBHC means every Illinois physician who takes care of the "people," the "Illinois consumers" who CBHC would have "expose these special interests." In other words, your patients.

The objective here, of course, is passage of either H.B. 2774 or S.B. 1495, both of which would create the Universal Health Care Act. Proponents say it will decrease health care costs, provide full and equal access to all Illinois citizens, save consumers' out-of-pocket expenses and reduce premium costs for business.

We know – and you know – that's baloney. The legislation will produce precisely the opposite results. Demand and cost of health care services will increase dramatically and will result in the eventual and inevitable rationing of health care. The state income tax will nearly triple. Businesses will be subject to a new 11 percent payroll tax. And the bureaucratic malaise that permeates administration of all government agencies from the post office to the Pentagon will be foisted on every resident in the state.

Those are the facts that ISMS and others presented at a recent joint House-Senate committee hearing on the Universal Health Care Act. You will be proud to know that ISMS testimony, especially on the economic impact of this legislation – read ultimate cost to taxpayers, i.e., the "people" – proved so cogent that others testifying used ISMS numbers when presenting their testimony.

But in politics, rhetoric and emotion can carry the day, and that's what the backers of these bills are banking on. So, we are back to an oft-repeated refrain: It's your turn. Your help is again needed.

Now, before you ask, "What can I do?" stop reading this column and look one page over to Dr. Dave Harmon's guest editorial. He says it far more eloquently than we can. (Read it right now, we'll wait for you. When you're finished, come back.)

Pretty good advice, isn't it? Educate yourself and your patients. Write or call your legislators and get your patients to do the same. ISMS can help you get and present the facts. Contact the ISMS Governmental Affairs Division at (312) 782-1654 or (800) 782-4767 for detailed information about how these bills will hurt, not help, our patients.

Believe it or not, contacting the folks who cast the votes does work, if enough people bother to take the time to do it. You owe it to yourselves and your patients to try. It's your turn, again. ▲

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## President's Column

To lead people,  
keep your ear  
to the ground

Arvind K.  
Goyal,  
M.D.

"There are good and bad things about this property," said the real estate agent. "To the north is the gas works, to the east a glue factory, to the south a fish and chips shop, and to the west is a sewage plant. Those are the only disadvantages."

"What are the advantages?" asked the prospective buyer.

"You can always tell which way the wind is blowing," said the agent.

Your state medical society has none of the above disadvantages. It is located on "magnificent" Michigan Avenue, south of the Chicago River – a rediscovered landmark since the flood in the underground tunnel. Yet the advantages remain. Thanks to the guiding policies determined by your House of Delegates, your dues support, ideas, efforts and time, and your alert and hardworking staff team, you always know which way the wind is blowing. And then our sails can be adjusted accordingly.

In my role as your new president, I have the honorable, yet unenviable, task of filling the same shoes filled by the 146 presidents before me.

A list of my privileges is in the mail, I am told. The list of my responsibilities, however, has been delivered by Federal Express.

This President's Column could become a two-way communication if you'll write back to me on issues that interest you, especially if you disagree. Please let me know, too, if you feel an issue needs to be discussed in this column. You will get a report of your President's Tour on a regular basis. You will see, hear and

talk to your President at some of your county society meetings. I have also asked to appear at some of your hospital medical staff meetings, and your specialty and ethnic society meetings, in an effort to increase your Society's opportunities to listen to you, bring back your ideas to work on, and to help develop consensus on matters important to you.

I will try to be available to personally take your phone calls in the Illinois State Medical Society offices at (800) 782-ISMS, ext. 1333 between 11 a.m. and noon on the first Wednesday of each month. If an emergency precludes my availability at that time, please be sure to leave a message, so that I can call you back the same day or the next.

To lead you, I need to walk behind you. I need to know what you know. Please continue to share with me your thoughts, your concerns, your gripes and equally important, your successes.

I remember that your Society got along well before me and, in all probability, will get along very well after me. It is this year in between that I am worried about. Please pray so I'll seek to be better than myself when I am acting as your president. ▲

ARVIND

Arvind K. Goyal, M.D.  
President



## Guest Editorial

### Stormy weather



by David A. Harmon, M.D.

If there's one thing I've learned from six years of medical practice in central Illinois, it's this: Illinois weather is unpredictable. Because I practice in a clinic that has no windows in my office, nor in the patient exam rooms, my nurse and I often hear weather changes before we see them. The sound of the wind whistling through the eaves, or the rain drumming on the roof, or the snowplow scraping clear the road to the hospital hint at a changing world outside the clinic walls.

If I really want to know what the weather is doing, I have to open one of the clinic doors and look outside. If it's a springtime thunderstorm rolling up from St. Louis, or simply a brilliant sunset across the cornfield to our west, my staff and I will, more often than not, take a moment to peer out and see Nature at her best or worst. Occasionally, we respond with action, racing out to roll up car windows, but usually we just watch.

*"As I look east to Washington, I don't just see thunderclouds forming. That's the 'mother of all storms' heading our way – and it's called national health insurance."*

These past few days, I've had a chance to reflect on what I heard at the educational seminar I attended during the ISMS House of Delegates annual meeting a few weeks ago. Fellow physicians, as I look east to Washington, I don't just see thunderclouds forming. That's the "mother of all storms" heading our way – and it's called national health insurance.

At the seminar, Thomas Scully, President Bush's adviser on health care policy, predicted that a national health insurance program will be enacted by Congress within the next two to three years. While it's hard to imagine Congress agreeing on anything other than a pay raise, no one

questions if a national health insurance program is going to happen. The only question is what kind of program it will be.

Too often in medicine, physicians learn of changes in the health care delivery system the same way I learn about changes in Jersey County weather – we hear noise through the walls of our practices. Occasionally, physicians even peek out to watch the show. Most of the time, though, we don't act, we just watch. Unfortunately, when a tornado blows through, there's often not a whole lot left to do after the fact, except damage control and salvage. Unless we physicians stop watching and reacting, and start actively guiding the debate about changes in health care delivery, and the changes in the way we provide insurance for that care, we'll find ourselves trying to salvage the scattered remnants of a once excellent health care system when we could be strengthening it to make it the best health care system available anywhere.

Sounds great, right? But all talk and no action makes Dr. Dave a big wind. So, what to do? In preparing for the annual thunderstorm/tornado season, three things have proven their worth: following the forecast; planting a windbreak; and attempting to harness or direct the winds of the storm. Applying these steps to the coming national health insurance policy debate means that we must first study and analyze the various policy options (i.e., voucher vs. single-payer vs. pay or play). Second, we must use our existing county and state medical societies to select the option that's best for our patients and educate every Illinois physician about our choice. Third, we must become individual "windmills" capable of channeling and directing this popular and powerful consumer demand for health insurance reform into a medical care system that builds on what is good and right with our current system, and corrects or redresses those elements that need improvement.

Specifically, as "windmills," we need to work within our communities to actively promote (and yes, financially support) the plan that will provide our patients with the best care. We need to speak to church groups, service clubs, health classes, senior citizen groups – in short, anyone who will listen – to push for that plan. Most important, in the daily doctor-patient encounters in our clinics and hospitals, let's take a few minutes to inform our patients of the program choices that exist, explain our reasons for selecting one particular option, and encourage them to contact their representatives in Washington and Springfield to enact that kind of program.

The ongoing debate over national health insurance policy options requires physicians to choose one of two approaches. We can passively await the health care changes selected by individuals who don't deliver that care, and are thus spared dealing with the consequences of their choice, or we can actively campaign for the health insurance option that will provide the best health care sys-



"How does the stork match up the chromosomes?"

tem. In the past six years since completing residency, I have witnessed many of my colleagues quietly accept, and then privately bemoan, the "cost-saving" measures forced on them by others. I fear that in our desire to remain professionally distanced from the political fights that brought about these changes, we have acquiesced to a diminution of health care quality that has simultaneously lessened the appeal and satisfaction of the medical profession.

As physicians united by our desire to provide the best possible care for our patients, we MUST act, and act

now, while these options are being debated. Our silent submission to accept whatever the coming storm delivers will do a grave disservice to both our patients and our profession. If we fail to actively participate in the determination of the health care system of the future, I predict a tragic decline in the quality of health care in the United States, and a possibly fatal blow to the medical profession we now serve. ▲

*Dr. Harmon, a family physician from Jerseyville, represents Jersey and Calhoun counties in the ISMS House of Delegates.*



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# Exchange officers elected

by Anna Brown

THE THREE OFFICERS of the Illinois State Medical Inter-Insurance Exchange Board of Governors were re-elected at the Exchange's annual meeting held in conjunction with the Illinois State Medical Society annual meeting. **Harold L. Jensen, M.D.**, of Harvey, will serve as chairman for a second term in 1992-93, while **Fred Z. White, M.D.**, of Peoria, will continue in the position of vice chairman. **Irwin A. Smith, M.D.**, of Northbrook, was re-elected secretary.

Dr. Jensen, an internist, is vice president of medical affairs at Ingalls Memorial Hospital in Harvey. He is a past chairman of the ISMS Board of Trustees and an Illinois delegate to the American Medical Association.

Dr. White, a family physician, is professor of clinical family practice and the director of the family practice residency program at the Uni-

versity of Illinois College of Medicine at Peoria. He has served as an ISMS trustee and president.

Dr. Smith, also a family physician, is on staff at Evanston and Glenbrook hospitals, and serves as assistant clinical professor of family practice at the Chicago Medical School.

## Board members elected

Two new members were elected to the Exchange Board of Governors. **Edward J. Fesco, M.D.**, of LaSalle; and **David W. Cromer, M.D.**, of Evanston, will join re-elected members **Richard A. Geline, M.D.**, of Glenview; **Henri S. Havdala, M.D.**, of Lincolnwood; **Boyd E. McCracken, M.D.**, of Greenville; and **Grover G. Sloan, M.D.**, of Harrisburg.

Dr. Fesco, a general surgeon, is president of the medical staff at Illinois Valley Community Hospital in Peru. He is an ISMS Second District trustee and a past president of ISMS.



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*Harold L. Jensen, M.D., (left) of Harvey, was re-elected chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors; Irwin A. Smith, M.D., (center) of Northbrook, was re-elected secretary; and Fred Z. White, M.D., (right) of Peoria, was re-elected vice chairman.*

He is also past president of the LaSalle County Medical Society, where he currently serves as secretary-treasurer. He has been a county delegate to the ISMS House of Delegates for 25 years.

Dr. Cromer, an obstetrician and gynecologist, is on the Executive Committee of the professional staff

and Board of Directors at Evanston Hospital, where he has been a medical staff member since 1965. He has been active in several professional societies, including the American College of Obstetricians and Gynecologists and the American Fertility Society. ▲



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## Exchange board members think caps are a great idea ...

*Illinois State Medical Inter-Insurance Exchange Board of Governors members Alan M. Roman, M.D., Edward J. Fesco, M.D., James B. Borgerson, M.D. and Henri S. Havdala, M.D., don ISMIE caps at the Exchange's 1992 annual meeting last month. ▲*

## New expert witness policy adopted

# Delegates link health care reform to caps on non-economic damages

by Kevin O'Brien

ANY REFORM of the American health care delivery system should be linked to establishing caps on non-economic damages in malpractice cases, said the 1992 Illinois State Medical Society House of Delegates. But delegates rejected a proposal to introduce a "no-fault" malpractice system in Illinois.

At its April 10-12 annual meeting in Oak Brook, the House also adopted new policy that says when physicians testify as expert witnesses in clinical matters in Illinois malpractice cases, they are engaged in the practice of medicine.

The House adopted a resolution offered by James E. Bane, M.D., from Winnebago County, that directs ISMS to support introduction of state legislation requiring that caps on non-economic damages be included "as an integral and necessary part of any health care policy reform plan adopted."

The House further directed ISMS to offer a resolution at the American

Medical Association annual meeting in June mandating the AMA to seek similar legislation at the federal level, and that ISMS and the AMA increase their public education efforts on the issue of tort reform and its linkage to health care reform policy.

Another resolution offered by Dr. Bane suggesting that Illinois adopt a "no-fault" system of malpractice compensation did not fare so well. Proponents contended that a no-fault system, in which compensation would be assessed regardless of alleged medical negligence, would correct inequities in the current adversarial system and cost less in the long run.

Opponents of the idea said the result would be just the opposite. "The number of cases [in a no-fault system] would be so much greater, that even though the cost per case would be less, the total cost would be greater," said M. LeRoy Sprang, M.D., chairman of the Cook County delegation.

In addition, delegates said that a no-fault compensation system would

compensate all "bad outcomes," not just injuries that may result from negligent care. Such a system, the delegates contended, would unfairly penalize physicians who experience bad outcomes for which they are not to blame.

## Expert witnesses

New policy adopted by the House specifies that physicians who testify as expert witnesses are practicing medicine when they so testify. Offered by Dr. Sprang for the Cook County delegation, the resolution also establishes guidelines under which physicians should conduct themselves when testifying.

Specifically, physician expert witnesses must exercise impartiality; be active in the practice of medicine; and express opinions based on a thorough knowledge and understanding of the pertinent facts of the case, and that are "based on science, truth, honesty, personal and professional experience." In addition, physicians should never testify as expert witnesses on a contingency ba-

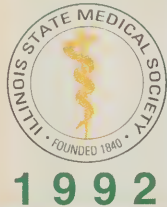
sis.

But while adopting most of the resolution's provisions, the House accepted a reference committee recommendation to extract an enforcement provision, and referred that language to the Board of Trustees for decision. The reference committee said that not all county medical societies would be equipped to execute the enforcement provision, as called for by the resolution.

Under the enforcement provision, the physician review committees of the county medical society would determine whether a physician's expert testimony "violates the acceptable standards of our community."

The physician review committees would review transcripts of case testimony to make such a judgment. If the committee believed that acceptable standards of practice had indeed been violated, it would be able "to recommend that charges be filed based upon the bylaws provisions then in effect." ▲





# Public health issues top House agenda

by Anna Brown

PUBLIC health issues were at the forefront of debate in reference committee and

on the floor of the Illinois State Medical Society House of Delegates at its annual meeting. The House adopted nearly all the public health resolutions, including a surprising reversal of a reference committee recommendation on handgun control. Only two resolutions on smoking failed to impress delegates, who felt existing ISMS policy on anti-smoking activities was sufficient.

Three resolutions on family violence, firearm safety and handgun control were endorsed by the House. Delegates quickly adopted the family violence resolution, introduced by



Clair M. Callan, M.D., of Lake County. The resolution stipulates that ISMS take an active role with the American Medical Association in condemning "senseless violence in families," and encourages physicians to look for signs of abuse in patients and participate in local domestic violence programs.

Farouk A. Hamouda, M.D., of Du-

Page County, introduced a resolution addressing firearm safety training. Reference committee discussion centered on the contention that many gun owners have little knowledge of current firearm safety features and practices. The resolution called for ISMS to support legislation banning handguns from children's play areas; to support educational and preventive programs on the dangers of firearms; to educate physicians and other health care providers on the danger of firearms in the home; and to "encourage appropriate state agencies to promote firearm safety."

A similar resolution addressing

handgun control drew heavy debate both in reference committee and on the House floor. Introduced by James E. Bane, M.D., of Winnebago County, the resolution called for ISMS to seek to introduce legislation in the Illinois General Assembly requesting education programs in schools; owner liability laws; state registration of all handguns; "buy back" programs; mandated locked gun storage in homes with minors; and more restrictive licensing. Although the reference committee recommended non-adoption on the grounds that the resolution duplicated existing ISMS policy, the House adopted the resolution.

## Participation in death penalty



Unfinished business from 1991 and a new resolution focused on physician participation in state executions. Held over from

last year and ultimately adopted was a proposal that ISMS introduce a resolution to the AMA requesting that physicians not be required to provide psychiatric treatment to condemned mentally ill prisoners in order to ensure their competence for execution. The resolution was adopted in lieu of one stating that psychiatrists prescribing psychotropic medication without the prisoner's consent would be in "serious violation of medical ethics," and recom-

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## Delegates debate public education

by Tamara Strom

SAYING THEY ARE forced to shoulder more than their fair share of blame for rising health care costs, ISMS delegates extensively debated how best to educate the public about the high cost of health care. Although three resolutions calling for extensive public education campaigns were introduced to the House, the delegates referred to the Board of Trustees for decision a substitute resolution combining different aspects of the resolutions.

Delegates speaking on the House floor said that given the prominence of health care as an issue in this election year, the need to disseminate accurate information to the public was urgent. Most agreed it was time physicians "took the bull by the horns" and entered the arena with other forces attempting to sway the public toward their side in the health care debate. At stake, they said, is "saving the best health care system in the world."

Keeping the delegates from wholly embracing the concept and adopting the policy outright were fiscal constraints (the Society is in the fifth year of its three-year no dues increase plan) and wariness of duplicating efforts already under way. The ISMS Council on Public Relations and Membership Services has developed a county-based public education campaign that will build on



mending in such cases that the death sentence be commuted to life imprisonment.

The other adopted resolution on the death penalty seeks to amend the state Code of Criminal Procedure by asking ISMS to seek to introduce legislation eliminating current secrecy provisions. Illinois law enacted in 1991 conceals from the state licensing authorities and the medical profession the names of all participants, including physicians, involved in state executions. The resolution builds on last year's action declaring physician participation in executions unethical.

#### Tattooing and electrolysis



While there was some question in reference committee as to the validity of making tattooing a licensed profession, a resolution introduced by Richard F. Bulger, M.D., of DuPage County, requiring such legislation was adopted by the House. The resolution also calls for tattoo parlors to be registered with the state department of health, to submit to inspection and conform to state sanitation standards, and to require informed consent.

Discussion of the resolution centered on the current popularity of tattoos among teenagers, as well as the health risks involved in tattooing, including hepatitis and possible HIV transmission. A clause that was rejected asked that ISMS seek legis-

lation to lower the age at which tattoos may be legally obtained from 21 to 18.

Another resolution introduced by Dr. Bulger calling for state licensing and regulation of electrolysis practitioners and facilities also passed the House with little debate.

#### Lead abatement and chelation therapy

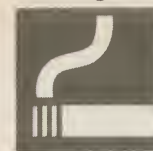


A resolution requesting ISMS to support legislation establishing lead abatement programs drew only favorable testimony in reference committee. Ann Marie Dunlap, M.D., of Cook County, introduced the resolution, which voiced concern that current screening and treatment legislation for children does

not include an effective lead abatement component. Reference committee testimony revealed concerns that the abatement process would be highly technical and costly. ISMS has supported previous lead poisoning legislation.

Delegates also adopted a resolution condemning the use of chelation therapy as unethical in the treatment of cardiovascular diseases, atherosclerosis, rheumatoid arthritis and cancer, until it is found effective in scientific studies. Introduced by Jerome S. Weiskopf, M.D., of Winnebago County, the resolution also calls for ISMS to communicate this position to the Illinois Department of Professional Regulation Medical Disciplinary Board so that disciplinary guidelines may be developed.

#### Smoking and helmets for motorcyclists



No new anti-smoking resolutions were adopted by the House. A resolution calling for an ISMS anti-smoking task

force failed; the reference committee suggested that such action would be duplicative because ISMS already supports a "vigorous stand against smoking" in the form of several legislative actions. The House referred to the ISMS Board of Trustees for decision a resolution prohibiting smoking in open and closed stadia, similar to one adopted in 1991.

ISMS will again support legislation requiring motorcyclists and their passengers to wear helmets. ▲

## merit of campaigns

existing education programs the Society sponsors. In fact, several physicians testified during reference committee that their participation in the ISMS senior citizen education program, "Partners for Health," is a good model for educating other groups on health care topics.

In general, delegates were enthusiastic about boosting efforts to educate patients on the reasons for soaring health care costs and the pros and cons of the various reform proposals circulating throughout the nation. After all, they said, they perform patient education in their offices every day on a variety of care and treatment regimen-related topics. Among the topics delegates cited for education efforts were highlighting the advantages of this country's existing system (albeit with certain flaws that must be corrected), outlining the costs of defensive medicine and how capping non-economic damage awards in malpractice suits would ease that pressure, and the benefits of preventive medicine.

Doctors also underscored the need to educate patients about taking responsibility for their own health care. Because many costly illnesses are preventable or attributable to lifestyle choices, physicians said, patients must be made aware of these risks and taught how to manage them. ▲

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As with all nitroglycerin medications, side effects may occur with Transderm-Nitro, the most common of which is headache. All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. Please consult brief summary of Prescribing Information on following page.

**Transderm-Nitro**<sup>®</sup>  
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## New term limits for ISMS officers and trustees

Office	Term
President-elect; Vice President	One one-year term; Lifetime eligibility of one full term for each office.
Secretary-Treasurer; Speaker of the House; Vice Speaker of the House	Maximum of two one-year terms each.
District Trustees	Three consecutive three-year terms; Lifetime eligibility of 12 years of service.

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#### Revised Dosage Information

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

#### INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention of angina pectoris due to coronary artery disease. Tolerance to the antianxiety effects of nitrates (measured by exercise stress testing) has been shown to be a major factor limiting efficacy when transdermal nitrates are used continuously for longer than 12 hours each day. The development of tolerance can be altered (prevented or attenuated) by use of a noncontinuous (intermittent) dosing schedule with a nitrate-free interval of 10-12 hours.

Controlled clinical trial data suggest that the intermittent use of nitrates is associated with decreased exercise tolerance, in comparison to placebo, during the last part of the nitrate-free interval; the clinical relevance of this observation is unknown, but the possibility of increased frequency or severity of angina during the nitrate-free interval should be considered. Further investigations of the tolerance phenomenon and best regimen are ongoing. A final evaluation of the effectiveness of the product will be announced by the FDA.

#### CONTRAINDICATIONS

Allergic reactions to organic nitrates are extremely rare, but they do occur. Nitroglycerin is contraindicated in patients who are allergic to it. Allergy to the adhesives used in nitroglycerin patches has also been reported, and it similarly constitutes a contraindication to the use of this product.

#### WARNINGS

The benefits of transdermal nitroglycerin in patients with acute myocardial infarction or congestive heart failure have not been established. If one elects to use nitroglycerin in these conditions, careful clinical or hemodynamic monitoring must be used to avoid the hazards of hypotension and tachycardia.

A cardioverter/defibrillator should not be discharged through a paddle electrode that overlies a Transderm-Nitro patch. The arcing that may be seen in this situation is harmless in itself, but it may be associated with local current concentration that can cause damage to the paddles and burns to the patient.

#### PRECAUTIONS

##### General

Severe hypotension, particularly with upright posture, may occur with even small doses of nitroglycerin. This drug should therefore be used with caution in patients who may be volume depleted or who, for whatever reason, are already hypotensive. Hypotension induced by nitroglycerin may be accompanied by paradoxical bradycardia and increased angina pectoris.

Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

As tolerance to other forms of nitroglycerin develops, the effect of sublingual nitroglycerin on exercise tolerance, although still observable, is somewhat blunted.

In industrial workers who have had long-term exposure to unknown (presumably high) doses of organic nitrates, tolerance clearly occurs. Chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitrates from these workers, demonstrating the existence of true physical dependence.

Several clinical trials in patients with angina pectoris have evaluated nitroglycerin regimens which incorporated a 10-12 hour nitrate-free interval. In some of these trials, an increase in the frequency of anginal attacks during the nitrate-free interval was observed in a small number of patients. In one trial, patients demonstrated decreased exercise tolerance at the end of the nitrate-free interval. Hemodynamic rebound has been observed only rarely; on the other hand, few studies were so designed that rebound, if it had occurred, would have been detected. The importance of these observations to the routine, clinical use of transdermal nitroglycerin is unknown.

##### Information for Patients

Daily headaches sometimes accompany treatment with nitroglycerin. In patients who get these headaches, the headaches may be a marker of the activity of the drug. Patients should resist the temptation to avoid headaches by altering the schedule of their treatment with nitroglycerin, since loss of headache may be associated with simultaneous loss of antianxiety efficacy.

Treatment with nitroglycerin may be associated with lightheadedness on standing, especially just after rising from a recumbent or seated position. This effect may be more frequent in patients who have also consumed alcohol.

# Governance issues occupy delegates

by Kevin O'Brien

SUBSTANTIVE governance matters occupied the 1992 Illinois State Medical Society House of Delegates as it debated adding a resident member to the Board of Trustees, adopted term limitations for ISMS officers and trustees, and established a conflict of interest policy for the Society's physician leadership.

During their April 10-12 annual meeting in Oak Brook, the delegates also reaffirmed hospital medical staff autonomy and adopted a new means to handle resolutions concerning issues of national scope or importance.

## Resident board member proposal defeated

Occupying a considerable portion of Saturday morning was debate on a proposal to seat a resident physician on the Board of Trustees. As originally submitted, the Resident Physicians Section-sponsored resolution called for voting privileges for the resident trustee, which the reference committee recommended not be adopted.

Extensive debate got under way, however, when Resident Physicians Section representative Marc E. Duerden, M.D., offered an amendment to provide for a non-voting board

member. The amendment was accepted, but the resolution itself was eventually defeated by a vote of 117-70.

Supporters of the proposal cited increased involvement and recruitment of resident physicians to organized medicine, and the value of more immediate resident perspective during board deliberations. Opponents indicated several concerns, including residents' lack of experience with Society governance mechanisms and economic considerations. Some delegates also expressed concern for the "sanctity of the executive session," citing concerns that confidential information might be compromised.

That concern was forcefully answered by several delegates, including Third District Trustee Joan E. Cummings, M.D. Dr. Cummings told the House that the Resident Physicians Section, which she has advised for several years, is a "responsible reasoned body of individuals who can assist our deliberations."

Two other factors, however, seemed to mitigate against passage of the resolution. The first, as articulated by ISMS Immediate Past Chairman George T. Wilkins Jr., M.D., involved the lack of a plan for implementing the resolution, if it were adopted. Dr. Wilkins noted that a resident member of the board would have to be elected by the House of Delegates, not the Resident Physicians Section. He asked for direction on matters of tenure and method of selection, in the event bylaws language would have to be developed.

Delegate discomfort with providing the Resident Physicians Section a seat on the board while the Hospital Medical Staff Section and the Medical Student Section lacked similar seats also seemed to play a role in the resolution's defeat.





"The real question, as I see it, is whether or not any constituent group within the state medical society needs specific recognition on the board, whether voting or non-voting," said Peoria County delegate Mark A. Shima, M.D. Acknowledging discomfort because he is "one of the younger delegates," Dr. Shima nevertheless joined several delegates in opposing the resolution on those grounds.

## Term limitations adopted

In 1991, resolutions to implement term limitations for ISMS officers and trustees were introduced but defeated. However, Dr. Wilkins, then-ISMS chairman, pledged to the House of Delegates that the board would study the issue and report back in 1992. The Board of Trustees-sponsored resolution was offered at this year's meeting in fulfillment of that pledge.

With the exception of the House of Delegates speaker and vice speaker, who were previously limited to two consecutive one-year terms each, there had been no limits on the number of terms officers could serve. The new rules limit physicians serving as president-elect and any of the vice presidents to a single one-year term in each office.

District trustees will now be able to

	0.1 mg/hr... Formerly described as 2.5 mg/24 hr
	0.2 mg/hr... Formerly described as 5 mg/24 hr
	0.4 mg/hr... Formerly described as 10 mg/24 hr
	0.6 mg/hr... Formerly described as 15 mg/24 hr

After normal use, there is enough residual nitroglycerin in discarded patches that they are a potential hazard to children and pets.

A patient leaflet is supplied with the systems.

#### Drug Interactions

The vasodilating effects of nitroglycerin may be additive with those of other vasodilators. Alcohol, in particular, has been found to exhibit additive effects of this variety.

Marked symptomatic orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustments of either class of agents may be necessary.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

No long-term animal studies have examined the carcinogenic or mutagenic potential of nitroglycerin. Nitroglycerin's effect upon reproductive capacity is similarly unknown.

#### Pregnancy Category C

Animal reproduction studies have not been conducted with nitroglycerin. It is also not known whether nitroglycerin can cause fetal harm when administered to a pregnant woman or whether it can affect reproductive capacity. Nitroglycerin should be given to a pregnant woman only if clearly needed.

#### Nursing Mothers

It is not known whether nitroglycerin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when nitroglycerin is administered to a nursing woman.

#### Pediatric Use

Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to nitroglycerin are generally dose-related, and almost all of these reactions are the result of nitroglycerin's activity as a vasodilator. Headache, which may be severe, is the most commonly reported side effect. Headache may be recurrent with each daily dose, especially at higher doses. Transient episodes of lightheadedness, occasionally related to blood pressure changes, may also occur. Hypotension occurs infrequently, but in some patients it may be severe enough to warrant discontinuation of therapy. Syncope, crescendo angina, and rebound hypertension have been reported but are uncommon.

Extremely rarely, ordinary doses of organic nitrates have caused methemoglobinemia in normal-seeming patients. Methemoglobinemia is so infrequent at these doses that further discussion of its diagnosis and treatment is deferred (see Overdosage).

Application-site irritation may occur but is rarely severe.

In two placebo-controlled trials of intermittent therapy with nitroglycerin patches at 0.2 to 0.8 mg/hr, the most frequent adverse reactions among 307 subjects were as follows:

	Placebo	Patch
Headache	18%	63%
Lightheadedness	4%	6%
Hypotension, and/or syncope	0%	4%
Increased angina	2%	2%

#### OVERDOSAGE

##### Hemodynamic Effects

The ill effects of nitroglycerin overdose are generally the result of nitroglycerin's capacity to induce vasodilation, venous pooling, reduced cardiac output, and hypotension. These hemodynamic changes may have protean manifestations, including increased intracranial pressure, with any or all of persistent throbbing headache, confusion, and moderate fever; vertigo; palpitations; visual disturbances; nausea and vomiting (possibly with colic and even bloody diarrhea); syncope (especially in the upright posture); air hunger and dyspnea, later followed by reduced ventilatory effort; diaphoresis, with the skin either flushed or cold and clammy; heart block and bradycardia; paralysis; coma; seizures; and death.

Laboratory determinations of serum levels of nitroglycerin and its metabolites are not widely available, and such determinations have, in any event, no established role in the management of nitroglycerin overdose.

No data are available to suggest physiological maneuvers (e.g., maneuvers to change the pH of the urine) that might accelerate elimination of nitroglycerin and its active metabolites. Similarly, it is not known which, if any, of these substances can usefully be removed from the body by hemodialysis.

No specific antagonist to the vasodilator effects of nitroglycerin is known, and no intervention has been subject to controlled study as a therapy of nitroglycerin overdose. Because the hypotension associated with nitroglycerin overdose is the result of venodilation and arterial hypovolemia, prudent therapy in this situation should be directed toward an increase in central fluid volume. Passive elevation of the patient's legs may be sufficient, but intravenous infusion of normal saline or similar fluid may also be necessary.

The use of epinephrine or other arterial vasoconstrictors in this setting is likely to do more harm than good.

In patients with renal disease or congestive heart failure, therapy resulting in central volume expansion is not without hazard. Treatment of nitroglycerin overdose in these patients may be subtle and difficult, and invasive monitoring may be required.

#### Methemoglobinemia

Nitrate ions liberated during metabolism of nitroglycerin can oxidize hemoglobin into methemoglobin. Even in patients totally without cytochrome b<sub>5</sub> reductase activity, however, and even assuming that the nitrate moieties of nitroglycerin are quantitatively applied to oxidation of hemoglobin, about 1 mg/kg of nitroglycerin should be required before any of these patients manifests clinically significant ( $\geq 10\%$ ) methemoglobinemia. In patients with normal reductase function, significant production of methemoglobin should require even larger doses of nitroglycerin. In one study in which 36 patients received 2-4 weeks of continuous nitroglycerin therapy at 3.1 to 4.4 mg/hr, the average methemoglobin level measured was 0.2%; this was comparable to that observed in parallel patients who received placebo.

Notwithstanding these observations, there are case reports of significant methemoglobinemia in association with moderate overdoses of organic nitrates. None of the affected patients had been thought to be unusually susceptible.

Methemoglobin levels are available from most clinical laboratories. The diagnosis should be suspected in patients who exhibit signs of impaired oxygen delivery despite adequate cardiac output and adequate arterial pO<sub>2</sub>. Classically, methemoglobinemic blood is described as chocolate brown, without color change on exposure to air.

When methemoglobinemia is diagnosed, the treatment of choice is methylene blue, 1-2 mg/kg intravenously.

#### DOSE AND ADMINISTRATION

The suggested starting dose is between 0.2 mg/hr\*, and 0.4 mg/hr\*. Doses between 0.4 mg/hr\* and 0.8 mg/hr\* have shown continued effectiveness for 10-12 hours daily for at least one month (the longest period studied) of intermittent administration. Although the minimum nitrate-free interval has not been defined, data show that a nitrate-free interval of 10-12 hours is sufficient (see INDICATIONS AND USAGE). Thus, an appropriate dosing schedule for nitroglycerin patches would include a daily patch-on period of 12-14 hours and a daily patch-off period of 10-12 hours.

Although some well-controlled clinical trials using exercise tolerance testing have shown maintenance of effectiveness when patches are worn continuously, the large majority of such controlled trials have shown the development of tolerance (i.e., complete loss of effect) within the first 24 hours after therapy was initiated. Dose adjustment, even to levels much higher than generally used, did not restore efficacy.

#### PATIENT INSTRUCTIONS FOR APPLICATION OF SYSTEM

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0.2 mg/hr	25 mg	10 cm <sup>2</sup>	30 Systems...NOC 57267-905-26 **30 Systems...NOC 57267-905-42 **100 Systems...NOC 57267-905-30
0.4 mg/hr	50 mg	20 cm <sup>2</sup>	30 Systems...NOC 57267-910-26 **30 Systems...NOC 57267-910-42 **100 Systems...NOC 57267-910-30
0.6 mg/hr	75 mg	30 cm <sup>2</sup>	30 Systems...NOC 57267-915-26 **30 Systems...NOC 57267-915-42 **100 Systems...NOC 57267-915-30

\*Rated release in vivo. Release rates were formerly described in terms of drug delivered per 24 hours. In these terms, the supplied Transderm-Nitro systems would be rated at 2.5 mg/24 hr (0.1 mg/hr), 5 mg/24 hr (0.2 mg/hr), 10 mg/24 hr (0.4 mg/hr), and 15 mg/24 hr (0.6 mg/hr).

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#### References:

- Brady EM, Gold OG, Rosenbach HJ. Antianxiety efficacy of transdermal nitroglycerin and oral nitrates: The ACTION Study. *Cardiovasc Rev Rep.* October 1988; 40-44.



# Williamson advocates health care improvement

by Anna Brown

U.S. SENATE candidate Richard S. Williamson called for fundamental change in the American health care system, but without implementing a Canadian-style national health service, when he addressed physicians April 11 at the Illinois State Medical Society's annual Public Affairs Breakfast.

"My opponent has embraced the Canadian system, and she's just wrong," he said of Democrat senate candidate Carol Moseley Braun's health care stance. "The Canadian system has costs rising faster than



Richard S. Williamson, Republican candidate for the U.S. Senate, says the American health care system needs reform, but that a Canadian-style system is not the way to do it.

the health care costs in the United States. But I feel the health care system has to be improved."

Williamson listed what he termed the "three basic issues" in health care reform: access, cost containment and prevention. To address these issues, Williamson proposes creating risk pools for the uninsured who are between jobs, movement toward a "universal card" for cost containment, and "going after" tort reform by establishing a cap on non-economic damages in medical malpractice cases.

"But prevention is where you really deal with health care costs," he said, noting that he would support more resources going to schools and un-

derprivileged areas for lifestyle education on drug and alcohol abuse, smoking, eating and exercise. Williamson said he also supports more funding for medical research, especially for breast and cervical cancer treatment and prevention.

"These are legitimate costs that the federal government can help with," he said. "I will work with you on legitimate problems and fight those who want simple solutions."

On the issue of abortion, Williamson proclaimed himself "firmly pro-choice," although he said he is personally opposed to the procedure. He does not, however support taxes going to pay for abortion. He supports fetal tissue research, say-

ing that it should go forward if it will help to save lives. He said he is against the abortion "gag rule," a decision he made shortly before addressing the physician group, because "people should be able to find out what's going on."

On other issues, Williamson said he supports term limitations, promising he would step down after two terms. He stressed the importance of measures that would "force Congress to do the job it should be doing," such as a line-item veto for the president and requiring a "super majority" before taxes could be increased.

"No law passed by Congress should ever apply to us, but not to them," he said. "I believe we need to go forth with a smaller government, with less taxes and less spending." ▲

## Governance (continued)

serve only three consecutive three-year terms, with a lifetime maximum of 12 years' service. The new rules take effect July 1, and district trustees already seated on that date will be allowed to complete their full terms.

## Conflict of interest

ISMS now has a policy governing conflict of interest for physicians serving in ISMS leadership positions. Physicians serving in elected positions, or on an ISMS council or committee, will henceforth be required to disclose any "direct or indirect interest, financial or otherwise, in the outcome of any transaction or matter involving the Society."

The House reaffirmed hospital medical staff autonomy by adopting a resolution saying that "no member of the hospital medical staff lose(s) protection under the hospital medical staff bylaws because of any contractual relationship," and that if a physician with a hospital contract holds a medical staff office, "the physician's duty is to serve the broader interests of the medical staff rather than only contracted physicians or the hospital administration."

## Refer for national action

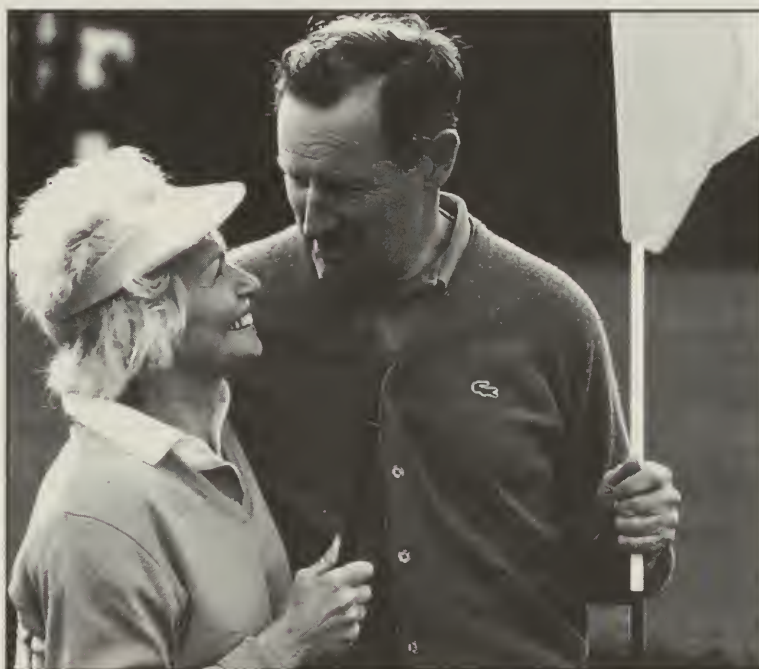
The House adopted a new method of dealing with resolutions that address issues of national scope. In addition to referring resolutions to the Board of Trustees for study and report, or for decision, or to the AMA, delegates are now able to refer for "national action." This allows the board to directly contact congressional representatives or federal agencies to fulfill a resolution's intent. ▲



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# Delegates mix business with pleasure at 1992 ISMS annual meeting



*Above: Carol Gapsis, of Morton, was installed as president during the ISMS Auxiliary's annual meeting.*

*Right: Three years of leadership: ISMS Immediate Past President Robert M. Reardon, M.D. (left); 1990-91 President James H. Andersen, M.D. (center); and new President Arvind K. Goyal, M.D.*



*Above: Limited Edition – Jazz and Vocal Sounds of the Illinois Wesleyan University School of Music entertains at President's Night.*



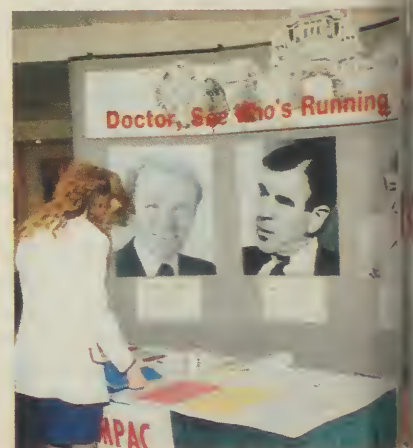
*Above: Fred Z. White, M.D., (left) of the downstate caucus and M. LeRoy Sprang, M.D., of the Cook County caucus nominate new ISMS officers on the House floor.*

*Below: The ISMS House of Delegates addressed 91 resolutions during the three-day meeting.*

*Left: New inductees to the ISMS Fifty-Year Club.*



*Above: ISMS and Auxiliary Past Presidents Gayle and Robert M. Reardon, M.D. take a break from their official duties.*







From left: Medical students Scott Reid, Charles Rainey, Sue Dillon, K. Paul Boyev and Jennifer Durham-Risinger exchange views at the annual meeting.



Left: Auxilians sport spring hats at the AMA-ERF Boutique.

Above: Lawrence A. Hirsch, M.D., enjoys a picnic lunch at the Exchange luncheon.  
Below: Richard A. Geline, M.D., (left) chairman of Reference Committee D, discusses the committee's recommendations with Speaker of the House of Delegates Raymond E. Hoffmann, M.D.



Above: Delegates confer on the House floor.  
Left: The Illinois State Medical Society Political Action Committee booth spotlights politicians with anti-medicine agendas.



Above: House Speaker Raymond E. Hoffmann, M.D., and Vice Speaker Ulrich F. Danckers, M.D., (left) lead new delegate orientation for first-time House members.  
Left: Sixteen past ISMS presidents gathered during the annual meeting to reminisce about old times.

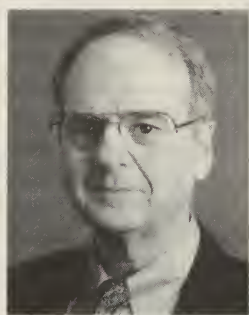


# ISMS House elects officers, trustees for 1992-93

THE ILLINOIS State Medical Society House of Delegates elected new officers and trustees April 12 during the Society's annual meeting in Oak Brook.

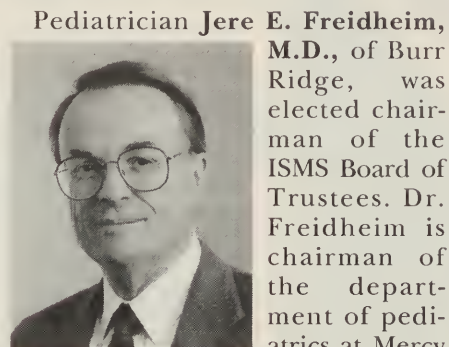
**Arvind K. Goyal, M.D.**, a family physician from Rolling Meadows, was installed as president. A graduate of the Indian Government Medical College, Punjab University, Dr. Goyal received a master's degree in public health from the University of Illinois School of Public Health. He is past

president of the Chicago Medical Society. He also is chairman of the Illinois State Medical Licensing Board. He is a member of the attending staff at Alexian Brothers Medical Center in Elk Grove Village and Northwest Community Hospital in Arlington Heights.

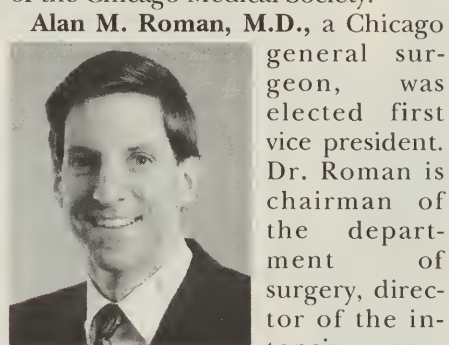


President-elect **Arthur R. Traugott, M.D.**, (left) a clinical psychiatrist, heads the Division of Psychiatry at the Carle Clinic in Urbana. He is medical

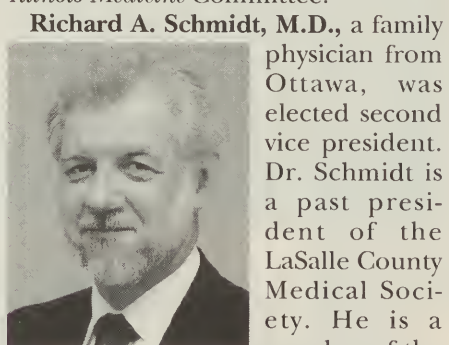
director of the Carle Pavilion Hospital and serves on the board of the Carle Foundation. Dr. Traugott is a past member of the Champaign County Mental Health Board and past president of the Champaign County Medical Society. He chaired the ISMS Council on Mental Health and Addiction and has served two terms as Eighth District trustee. Most recently, he was ISMS first vice president.



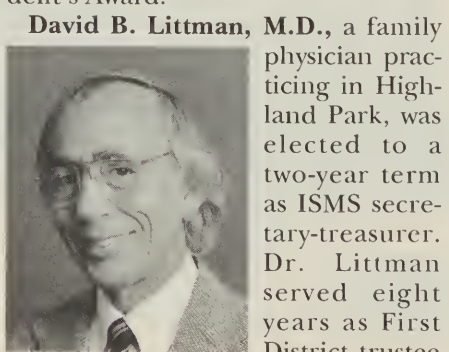
Pediatrician **Jere E. Freidheim, M.D.**, of Burr Ridge, was elected chairman of the ISMS Board of Trustees. Dr. Freidheim is chairman of the department of pediatrics at Mercy Hospital and Medical Center in Chicago and clinical assistant professor at the University of Chicago. For the past three years, he served as a Third District trustee. Dr. Freidheim has held numerous ISMS posts including service in 1986-87 as Society president. He is also a past president of the Chicago Medical Society.



**Alan M. Roman, M.D.**, a Chicago general surgeon, was elected first vice president. Dr. Roman is chairman of the department of surgery, director of the intensive care unit and a member of the Executive Committee at St. Francis Hospital and Health Center in Blue Island. He is president-elect of the Chicago Medical Society and chairman of its Board of Trustees. A Third District trustee since 1990, Dr. Roman has served on several ISMS councils and committees, including the Society's Political Action Committee Council and Executive Committee and the Illinois Medicine Committee.

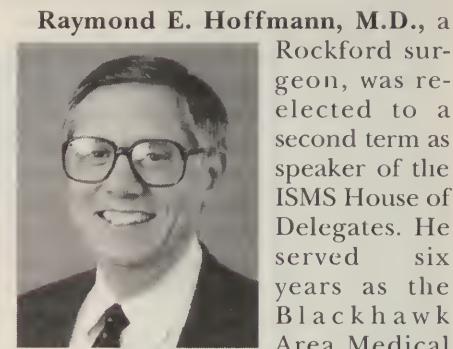


**Richard A. Schmidt, M.D.**, a family physician from Ottawa, was elected second vice president. Dr. Schmidt is a past president of the LaSalle County Medical Society. He is a member of the Illinois Academy of Family Physicians' Board of Directors, and received the Academy's 1990 President's Award.

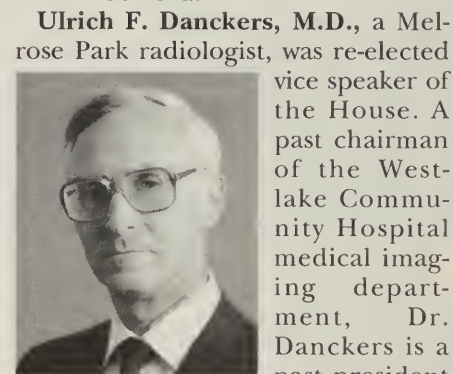


**David B. Littman, M.D.**, a family physician practicing in Highland Park, was elected to a two-year term as ISMS secretary-treasurer. Dr. Littman served eight years as First District trustee and is past president of the Lake County Medical Society. He is a member of the Illinois State Medical

Inter-Insurance Exchange Board of Governors and serves on the Illinois Medicine Committee.



**Raymond E. Hoffmann, M.D.**, a Rockford surgeon, was re-elected to a second term as speaker of the ISMS House of Delegates. He served six years as the Blackhawk Area Medical Association chairman and is a member of the Exchange Board of Governors. He is a clinical associate professor in the Department of Surgery at the University of Illinois College of Medicine at Rockford and is affiliated with Saint Anthony Medical Center in Rockford.



**Ulrich F. Danckers, M.D.**, a Melrose Park radiologist, was re-elected vice speaker of the House. A past chairman of the Westlake Community Hospital medical imaging department, Dr. Danckers is a past president of the Chicago Medical Society and served two terms as Third District trustee.

## Trustees elected

Several newly elected trustees will join the board for 1992-93. **Robert M. Reardon, M.D.**, a Bloomington ophthalmologist, was elected trustee-at-large following a year of service as ISMS president. Dr. Reardon has served as first vice president, speaker of the House of Delegates and delegate to the AMA. He also is a past president of the McLean County Medical Society.

**Alfred J. Clementi, M.D.**, a Palatine general surgeon, rejoins the board as a Third District trustee. Dr. Clementi served as secretary-treasurer for the past two years, and is currently chairman of the ISMS delegation to the AMA.

**Ronald L. Ruecker, M.D.**, a Decatur internist and gastroenterologist, was elected Seventh District trustee. Dr. Ruecker is past president of the Macon County Medical Society.

**Robert E. Welke, M.D.**, an Urbana urologist, was elected Eighth District trustee. Dr. Welke is past president of both the Illinois Urologic Society and the Illinois State Urological Society.

**Erlo Roth, M.D.**, a Willowbrook pathologist, was elected Eleventh District trustee. Dr. Roth is president of the Illinois Society of Pathologists, and is past president of the DuPage County Medical Society.

Re-elected trustees include: **Edward J. Fesco, M.D.**, of LaSalle, Second District; **Jere E. Freidheim, M.D.**, of Hinsdale, **Biswamay Ray, M.D.**, of Oak Brook, and **John F. Schneider, M.D.**, of Flossmoor, Third District; **Jane L. Jackman, M.D.**, of Springfield, Fifth District; and **William E. Kobler, M.D.**, of Rockford, Twelfth District. ▲

Compiled by Anna Brown, Rachel Brown and Kathy Meyer.

## YOCON® YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

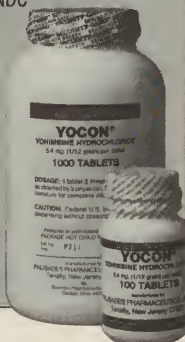
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# Resident financial issues, work conditions debated

by Anna Brown

RESIDENT physicians made their voices heard on the floor of the Illinois State Medical Society House of Delegates during its annual meeting. In addition to lobbying for a non-voting resident position on the Board of Trustees – a resolution that ultimately failed – residents and other delegates spoke up on their most frustrating financial difficulty: repayment of student loans.

A resolution that sparked considerable House debate but was not adopted addressed residents' concerns about work hours compared to compensation for other entry-level

health care positions. Introduced by student delegate Charles Rainey, the resolution led to heavy reference committee discussion, mostly centered on the difficulty of loan repayment for physicians still in training.

The resolution asked ISMS to present a resolution to the American Medical Association requesting that it "undertake a study to determine average compensation offered to resident physicians," taking into consideration resident work hours, living expenses and financial obligations such as student loan repayment. The resolution also called for educating both the public and the medical profession on resident financial issues.

While the reference committee agreed that misconceptions exist about residents' salaries and their ability to repay hefty loans, it did not recommend the resolution be adopted, reporting that studies had already been conducted and the AMA is already on record opposing federal legislation that restricts loan deferments.

Another resolution affecting residents was adopted by the House. The late resolution, introduced by student delegate Richard Z. Toptani, directed ISMS to submit a resolution to the AMA amending its current policy on physicians who default on medical educational loans.

The resolution requests that the AMA support physicians "experiencing severe, unavoidable economic difficulties" in working out loan repayment plans; that it deplore only physicians who have the ability to pay but fail to do so; that it encourage obligations be met in a "timely, but reasonable fashion"; and that the association renew "its commitment to support financial assistance programs for medical students to the fullest extent." The reference committee agreed with testimony that since medical education costs are "skyrocketing," physicians should not be penalized for economic hardship. ▲

## BuSpar® (buspirone HCl)

**References:** 1. Data on file, Bristol-Myers Squibb Company. 2. Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clonazepam in anxious outpatients with or without depressive symptoms. *Psychopharmacology*. 1992;25:10-21. 3. Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multicenter, double-blind evaluation of buspirone. *Neuropsychobiology*. 1989;21:124-130. 4. Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med*. 1987;82(suppl 5A):20-26. 5. Newton RE, Marunycz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med*. 1986;80(suppl 3B):17-21.

**Contraindications:** Hypersensitivity to buspirone hydrochloride.

**Warnings:** The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

**Precautions:** **General**—Interference with cognitive and motor performance: Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

**Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients:** Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

**Possible concerns related to buspirone's binding to dopamine receptors:** Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

**Information for Patients**—Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

**Drug Interactions**—Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

**Pregnancy: Teratogenic Effects**—Pregnancy Category B: Should be used during pregnancy only if clearly needed.

**Nursing Mothers**—Administration to nursing women should be avoided if clinically possible.

**Pediatric Use**—The safety and effectiveness have not been determined in individuals below 18 years of age.

**Use in the Elderly**—No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

**Use in Patients with Impaired Hepatic or Renal Function**—Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

**Adverse Reactions (See also Precautions): Commonly Observed**—The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

**Associated with Discontinuation of Treatment**—The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

**Incidence in Controlled Clinical Trials**—Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: **Cardiovascular:** Tachycardia/palpitations 1%. **CNS:** Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. **EENT:** Blurred vision 2%. **Gastrointestinal:** Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. **Musculoskeletal:** Musculoskeletal aches/pains 1%. **Neurological:** Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. **Skin:** Skin rash 1%. **Miscellaneous:** Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

**Other Events Observed During the Entire Premarketing Evaluation**—The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. **Cardiovascular**—frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. **Central Nervous System**—frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. **EENT**—frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. **Endocrine**—rare: galactorrhea, thyroid abnormality. **Gastrointestinal**—infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. **Genitourinary**—infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. **Musculoskeletal**—infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. **Neurological**—infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. **Respiratory**—infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. **Sexual Function**—infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. **Skin**—infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. **Clinical Laboratory**—infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. **Miscellaneous**—infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

**Postintroduction Clinical Experience**—Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

**Drug Abuse and Dependence: Controlled Substance Class**—Not a controlled substance.

**Physical and Psychological Dependence**—Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

**Overdosage: Signs and Symptoms**—At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

**Recommended Overdosage Treatment**—General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

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Now indicated for the relief of persistent anxiety with coexisting depressive symptoms.\*

▲ Anxiolytic efficacy demonstrated in anxious patients with or without coexisting depressive symptoms.<sup>2</sup>

▲ Relief of anxiety symptoms begins within 1 week, progresses steadily through the fourth week of therapy.<sup>3</sup>

▲ Nonaddictive, no more sedation (10%) than seen with placebo (9%).<sup>4,5</sup>

▲ The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

Progressive Relief of Persistent Anxiety.

\*BuSpar is not indicated for the relief of primary depressive disorder.

Please see references and brief summary on adjacent page.

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From left: Carolyn Kobler, Nancy Hoffmann and Sylvia Eberle accept the Non-Physician Public Service Award on behalf of the Winnebago County Medical Society Auxiliary, honored for its public education efforts in the Rockford area.

## Public service award winners focus on health education

by Rachel Brown

THE ILLINOIS STATE Medical Society's House of Delegates took time out of a busy annual meeting schedule to honor Public Service Award winners James P. Monahan, M.D., and the Winnebago County Medical Society Auxiliary for their community public service efforts.

Dr. Monahan, a Waukegan cardiologist, was honored April 11 at the Oak Brook Hills Hotel for his work with the Lake County Medical Society's mini-internship program. As chairman of the county medical so-

ciety's Community Relations Committee, Dr. Monahan heads the program, which provides government, business and community leaders an opportunity to experience medicine firsthand by spending two days with local physicians.

"[Dr. Monahan] has given generously of his time to the support and development of the mini-internship program, which has successfully opened communications and addressed mutual problems concerning the health care environment," said Mark Nolan Hill, M.D., past president of the Lake County Medical Society.

Under Dr. Monahan's direction, involvement in the county program has grown to more than 60 physician participants, said Dr. Hill. Community participants in the Lake County program have included local fire and police department chiefs, attorneys, coroners and insurance claims analysts.

"The program is crucial to shaping future health care in Illinois by opening the doors to discussion between physicians and decision makers," said George T. Wilkins Jr., M.D., who in his role as chairman of the ISMS Board of Trustees presented Dr. Monahan with his award. "[The Lake County program's] success has inspired the state society and nine other county medical societies to implement similar programs in their communities."

### Auxilians' contributions honored

Nancy Hoffmann, Sylvia Eberle and Carolyn Kobler accepted the non-physician public service award on behalf of the Winnebago County Medical Society Auxiliary. The Auxiliary was honored for its health education and fund-raising efforts in the Rockford area.

"Through individual and group efforts, the Auxilians of Winnebago County have had a significant impact on the health of countless people in the community," said Dr. Wilkins.

The Winnebago County Auxiliary, which boasts 240 members, has been involved in various community service activities since its inception in 1952. The most successful campaign in the past year was the development of an enhanced 911 emergency system in Winnebago County, said Karen Jasper, Auxiliary president.

"[The Auxiliary] was instrumental in getting the system established by handling the publicity, talking to groups and mailing brochures" to residents, Jasper said.

Through another program, targeted at Winnebago County high school students, the Auxiliary organized presentations and distributed videotapes promoting careers in the health care professions.

In addition, the Auxiliary has made a five-year, \$45,000 commitment to provide displays explaining various parts of the body to the Discovery Center, a children's museum in Rockford. Last year the Auxiliary raised more than \$8,400 for area residents interested in pursuing nursing, respiratory therapy and other medical careers. ▲



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James P. Monahan, M.D., (left) accepts the Physician Public Service Award from George T. Wilkins Jr., M.D., during the ISMS Annual Meeting.

## Universal health system rejected

# ISMS House adopts health care reform policy

by Tamara Strom

REJECTING SINGLE-PAYER, government-run national health insurance as the wrong prescription for what ails the U.S. health care delivery system, the ISMS House of Delegates adopted policy calling for reform to build on the strengths of the current system. The delegates called the U.S. health care system the best in the world, and one that works well for the majority of Americans.

Although delegates debated four resolutions calling for ISMS support of various reform plans – such as

“pay or play” and the American Medical Association’s “Health Access America” – all were rejected. Instead, the House endorsed a Board of Trustees report outlining 10 general principles for reform.

The principles, which now constitute ISMS policy on reforming the U.S. health care system, stress physicians’ belief that the present public-private multipayer system poses the best hope for the future. Single-payer, government-run systems, delegates said, are doomed to failure because they promise “everything to everyone.” While the principles em-

phasize that access to health care should be readily available to all citizens, they say health care should not be free for those who can pay.

The physician delegates endorsed major reform of the health insurance system, but said keeping patient copayments and deductibles would help the public understand the actual costs of care. The physicians reiterated their long-held belief that patients are ultimately responsible for their health and for seeking the care they need.

The principles establish a frame-

(continued on page 19)

## AXID<sup>®</sup> nizatidine capsules

**Brief Summary.** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer* – for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy* – for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)* – for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests** – False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions** – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility** – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy – Teratogenic Effects – Pregnancy Category C** – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers** – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use** – Safety and effectiveness in children have not been established.

**Use in Elderly Patients** – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic** – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular** – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS** – Rare cases of reversible mental confusion have been reported.

**Endocrine** – Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic** – Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental** – Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity** – As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other** – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to Axid have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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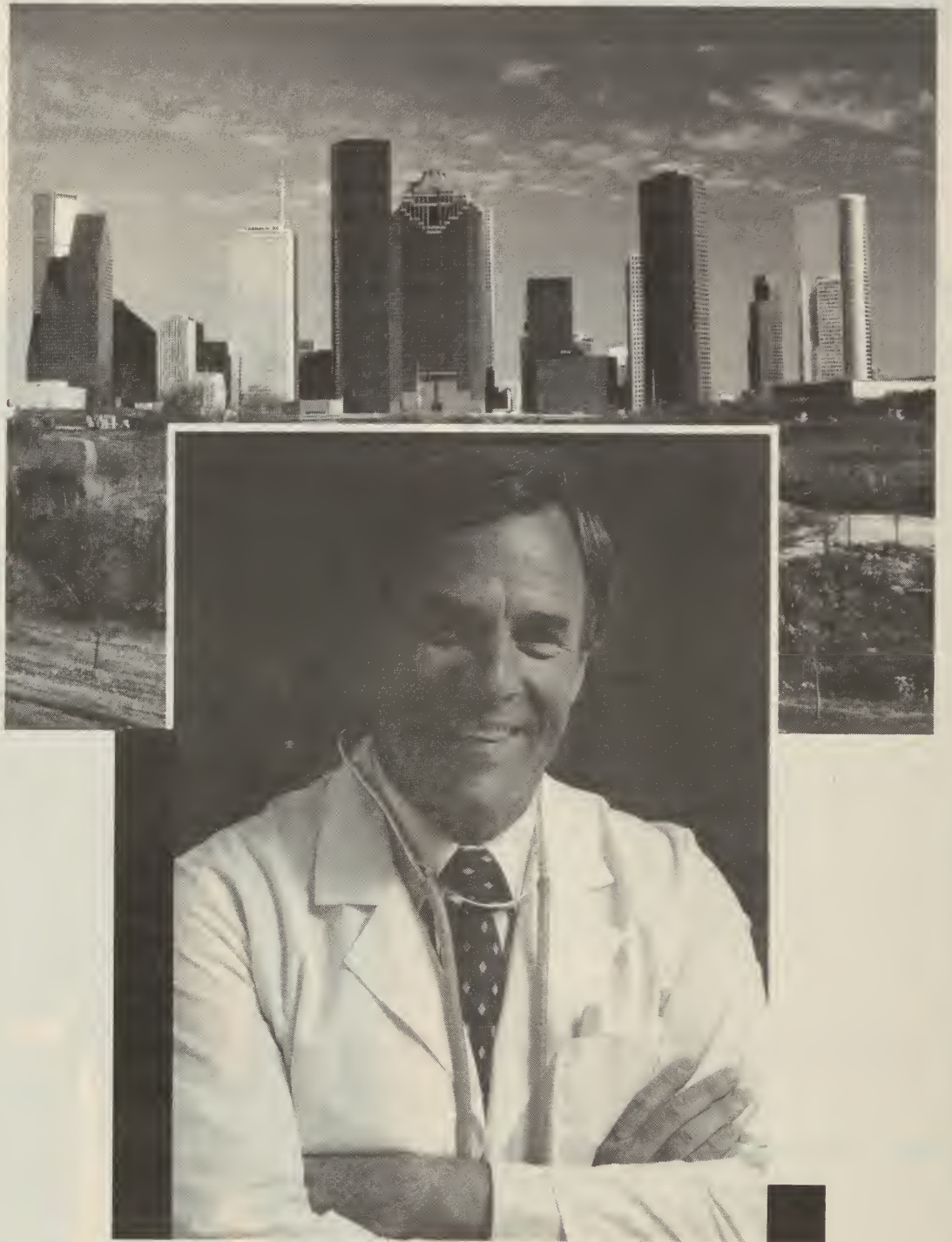
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# Access issues revisited

by Anna Brown

DELEGATES considered access to health care issues, including resolutions regarding post-surgical and obstetrical centers and certified nurse-midwives at the Illinois State Medical Society annual meeting.

Jaroslav F. Neskodny, M.D., a delegate for the ISMS Hospital Medical Staff Section; and Ann Marie Dunlap, M.D., delegate from Cook County, introduced resolutions to re-evaluate ISMS policy on post-surgical and obstetrical care centers. Reference committee testimony was heard from both proponents and opponents of PSOCs, centering on such issues as whether PSOCs actually improve access to care; whether they threaten the "ongoing financial viability" of hospitals; and the vital public concern over access to care. Delegates agreed that if PSOCs are to be established, "adequate quality assurance mechanisms must be in place."

The House adopted a substitute resolution, calling on ISMS to support PSOCs only if the facilities can obtain certificates of need; implement "adequate" peer review, credentialing and quality assurance measures; and "provide obstetrical care consistent with recognized obstetrical care guidelines."

Although the House rejected a resolution addressing hospital privileges for certified nurse-midwives, delegates engaged in considerable debate of the issue. Roger N. Klam, M.D., of Jackson County, who with Gary A. Goforth, D.O., of Washington County, introduced the resolution to improve access for pregnant women in rural Illinois, told the House, "My house is full of women who need to get delivered." He argued that rural physicians are not always able to meet the needs of their communities by themselves.

Other delegates suggested that the House address only issues pertaining to physicians, avoiding the adoption of policy regarding other health care workers. The reference committee concluded that the resolution did not "address the root of the problem," and was vague in intent, since Illinois already allows certified nurse-midwives to practice in hospitals "under protocol." The failed resolution would have expanded on policy adopted last year supporting trained nurse practitioners and physicians' assistants, provided they practice under physician supervision, and that physicians supervise no more than one assistant or nurse practitioner each. ▲

## Acute Care Task Force recommends guidelines for recovery, birthing centers

by Tamara Strom

IN KEEPING with ISMS House of Delegates policy, Gov. Jim Edgar's Acute Care Task Force in April recommended a pilot project to test the viability of recovery and birthing centers. Most of the task force's recommendations are included in H.B. 3687, the enacting legislation for the pilot project.

The governor convened the task force earlier this year to develop guidelines for the administration of recovery and birthing centers and approve appropriate models for each. The task force said the pilot project is needed to address access and cost issues in Illinois and will enable the state to discover, on an experimental basis, whether such centers would even work.

"We think it is important to explore new ways of providing care that can deliver quality consistent with that offered in the traditional hospital setting, but at a substantially reduced cost to both the patient and the institution," said ISMS President Arvind K. Goyal, M.D., a task force member. "Specifically, ISMS supports the concept of inpatient post-surgical and obstetrical centers

designed to deliver recovery care to patients following surgery, labor and delivery."

Many physician concerns about these centers were addressed and resolved satisfactorily by the task force, Dr. Goyal noted. For example, the Illinois Department of Public Health will provide oversight for the pilot centers, and project facilities will be required to obtain a certificate of need from the Illinois Health Facilities Planning Board. Additionally, recovery and birthing centers must meet strict guidelines to maintain quality assurance and ensure that patients receive care consistent with recognized obstetrical care guidelines.

H.B. 3687 specifically calls for three "alternative health care models" for each of the following areas: Chicago; Cook County outside Chicago; DuPage, Kane, Lake, McHenry and Will counties; municipalities with more than 50,000 people not included in the above communities; and rural areas. The models would receive operating licenses for one year and would be renewed annually if they are in "substantial compliance" with IDPH rules. ▲

## Health care reform policy

(continued from page 17)

work for discussion about how the country can proceed in reforming the health care system to include those who have fallen through the cracks and lack access. In adopting the principles, the delegates endorsed a concept whereby each person would have equal access to a basic set of health services. They did not, however, detail what this basic package would include, saying this is an issue with which society as a whole must grapple. The principles acknowledge that some rationing of high-cost or "marginally beneficial" health services may be necessary to maintain the overall cost of health care within available resources.

The delegates did say, however, that the basic plan – to be mandated at the federal level for all states – should emphasize cost-effective preventive care. Due to the price of long-term care, the delegates recommended this not be included in the basic health plan. Payment mechanisms to enact these principles were not addressed.

"Basic health care does not mean access to every type of care for everyone," Unfinished Business Report D says. "Employers and individuals should be able to purchase coverage beyond the basic health care package if they so desire and have appropriate resources to do such. Those who choose access to such care should be allowed to pay for it directly or through an insurance product."

Although delegates opposed the "pay or play" reform proposal as too costly for small-business owners, they did say employers have a responsibility to ensure their employees and dependents have access to health insurance that covers the minimum benefit package. Such employers would receive tax benefits as an incentive to

providing health insurance to their workers. These incentives would also apply to self-employed workers.

Also included in the principles are provisions for expanding the Medicare system and revamping the Medicaid system. Calling Illinois' present Medicaid program "complex and confusing," the new policy advocates a federally mandated, state-run program that gives states flexibility in administering the program and expanding the number of eligible patients. Physicians said a sliding pay scale should be introduced so individuals with the ability to pay something for their care would do so. The

state's poorest citizens would continue to receive free health care.

Inherent in the physicians' principles for reforming both government-paid and private-paid health plans is adequate and fair reimbursement for health professionals to ensure access. Adequate reimbursement, they say, will reduce the increasing pressure within the health care community to shift costs to those patients who have the ability to pay. In addition, while Medicare currently reimburses at a higher level than Medicaid, those rates will need to rise to cover the intensity of illness among the elderly, a rapidly growing popu-

lation segment.

Physician delegates reiterated their call for significant professional liability reform, namely capping non-economic damage awards in medical malpractice cases. By itself, this reform to the nation's tort system could save health care dollars by reducing the need for physicians to practice defensive medicine. Defensive medicine costs also could be contained if physicians were not held liable in the court system for failing to perform tests or procedures that society decides are too expensive or should not be included as part of the basic health package. ▲



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# Illinois physicians call for PRO changes, end of hassle factor

by Tamara Strom

FED UP WITH what they call an increasing hassle factor, Illinois State Medical Society physician delegates adopted policy calling for more responsible peer review activities, an end to questionable DME marketing efforts that expose doctors to fraud charges and protection of physician confidentiality in hospital data use.

Delegates expressed their displeasure about pressures in the current health care system that place harsh administrative burdens on physicians in the name of quality. Illinois physicians contended through House debate that many of these burdens — including some utilization review activ-

ities — are inherently anti-physician and anti-patient.

Earlier this year, the ISMS Board of Trustees sent a letter of no confidence to the U.S. Health Care Financing Administration about Crescent Counties Foundation for Medical Care, the Illinois PRO. A resolution from a delegate of the Peoria Medical Society called for House policy urging HCFA to reopen the bidding process to select the Illinois PRO this year. Last fall, Central Illinois Medical Review Organization (CIMRO) quit performing Medicare peer review activities as a CCFMC subcontractor, leaving Crescent Counties without any subcontractors. All CIMRO physician reviewers were

required to be recredentialed with Crescent Counties, a process still under way.

In the absence of CIMRO, downstate physicians contend, no area physicians are performing Level I downstate review. The physician delegates indicated their belief that true peer review should include physician reviewers from all over the state. While the PRO claims it is recruiting downstate reviewers, delegates called those efforts too little, too late.

In reference committee testimony, physicians cited the deteriorating relationship between doctors and Crescent Counties, saying that organized medicine held out the olive branch to the PRO but it was "stomped on

and broken." Complaints from downstate doctors now being reviewed by Crescent Counties are increasing, testifiers said.

In a related matter, delegates endorsed the concept that pre-certification requirements include reasonable time and opportunity for admitting physicians to speak with reviewing entities. The physician delegates also called for a ban on pre-certification requirements in emergency situations and directed the Society to actively oppose attempts by reviewers to obtain utilization information about any patient while being treated for an emergency condition.

Delegates also adopted policy to address increasing problems surrounding physician orders for durable medical equipment (DME). The federal government, under the Omnibus Budget Reconciliation Act of 1990, is cracking down on non-medically necessary Medicare-paid DME. HCFA is identifying many of these orders as Medicare fraud.

At the same time, DME vendors are stepping up marketing efforts to patients for convenient, but not always medically necessary equipment for at-home use. Too often, delegates said, the physician is not consulted about certifying the need for the equipment until after the patient buys or rents the equipment. When doctors are approached by their patients or the vendors to "post-certify," authorizing Medicare to reimburse for the equipment, they are put in a delicate position between their patients' wishes and the government's anti-fraud efforts.

Delegates called on the Society to inform the membership of the potential problems in this area and strongly oppose attempts to coerce physicians to certify need for DME. The House also opposed a potential Bush administration plan to force hospitals to arrange and bill for several Medicare services, including DME, even outside the hospital setting. Delegates also directed ISMS to bring this matter to the attention of the American Medical Association, asking the AMA to urge HCFA to educate Medicare patients about the agency's requirements for written physician certification for DME.

In other actions, the House adopted policy supporting ISMS' position that physician identifiers in hospital discharge data remain confidential and urging that use of the data be restricted to those purposes intended by state and federal law, including hospital demographic data, quality issues and payment concerns. The delegates expressed their strong opposition to using this data for marketing, economic credentialing or sharing the physician-sensitive data with individuals or entities outside the hospital of origin without consent from the medical staff or individual physicians.

Delegates also endorsed a resolution directing the Society to introduce legislation assuring prompt reimbursement of physicians' services in worker's compensation cases. Specifically, the resolution called for payment within 60 days after the doctor submits the claim, and if payment is not forthcoming in that time, payment of a penalty by the state to the physician of 1 percent a month. ▲

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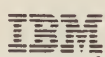
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July 26 - August 1, 1992
- ☐ Specialty Review in Internal Medicine  
August 2 - 9, 1992
- ☐ Specialty Review in General Surgery, Part I  
August 17 - 28, 1992
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Universal health

(continued from page 1)

specifications allows lawmakers to support “universal” access to health care without being labeled as supporting the tax increases necessary for implementation.

Supporters say the program would cost \$54 billion to implement. Estimates of the tax increases needed to fund the system included almost tripling the personal income tax and imposing an additional 11 percent in payroll taxes on businesses.

The vote sending the bill to the House floor split mainly along party lines, with 11 Democrats voting yes and eight Republicans and one Democrat voting no.

Saying the amendment was intended to hide the actual cost of the program, Rep. Jerry Weller (R-Morris) said, “Essentially, this is a Medicaid program for everyone.”

One legislator, Rep. Jeffrey M. Schoenberg (D-Skokie), missed the vote when the lengthy debate forced him to leave for another committee meeting. Schoenberg told *Illinois Medicine* that although he supports universal access to health care, he

opposes the single-payer model. “All of us who have a high level of interest in high quality health care recognize the shortcomings of the present health care system,” he said. “But this [plan] just defies economic gravity.”

Schoenberg, who joins Rep. Alfred G. Ronan (D-Chicago) as the two Democrats who opposed the plan, said he was “aggressively lobbied” to vote for the bill.

“It was clear the Democratic leadership wanted this bill out of committee,” Weller said. “What kind of pressure they’ll put on their caucus remains to be seen.”

ISMS President Arvind K. Goyal, M.D., testified against the legislation before the joint committee hearing April 22. Dr. Goyal said the single-payer system created by the bills promise unlimited “cradle to grave” medical services, including dental and vision care and long-term care.

“All of these services would be provided at no out-of-pocket expense to patients, regardless of how much they make. Virtually unlimited care with zero financial participation from patients makes this a fantasy,” Dr. Goyal told the committee. ▲

How they voted on universal health care ...

House Health Care Committee		Senate Public Health, Welfare & Corrections Committee	
Yes	No	Yes	No
David Phelps* (D-Eldorado)	Jerry Weller (R-Morris)	Margaret Smith* (D-Chicago)	Judy Baar Topinka (R-Berwyn)
Donne Trotter* (D-Chicago)	Robert Regan (R-Richton Park)	Ted Leverenz (D-Maywood)	Robert Raica (R-Chicago)
Bill Edley* (D-Macomb)	Dan Cronin (R-Elmhurst)	John Cullterton (D-Chicago)	Robert Madigan (R-Lincoln)
Lou Lang (D-Skokie)	Virginia Frederick (R-Lake Forest)	Thomas Dunn (D-Joliet)	Laura Kent Donahue (R-Quincy)
James Phelan* (D-Chicago)	Roger McAuliffe (R-Chicago)	Emil Jones (D-Chicago)	Doris Karpel (R-Roselle)
Michael Rotello* (D-Rockford)	Penny Pullen (R-Park Ridge)	William Marovitz* (D-Chicago)	William Mahar (R-Orland Park)
Jan Schakowsky* (D-Evanston)	Alfred Ronan (D-Chicago)	Frank Savickas (D-Chicago)	<b>Absent</b> James Rea (D-Christopher)
Ann Stepan* (D-Chicago)	Art Tenhouse (R-Quincy)		
Arthur Turner* (D-Chicago)	<b>Absent</b> Bill Black (R-Danville)		
Anthony Young* (D-Chicago)	Jeffrey Schoenberg (D-Skokie)		
Paul Williams [(D-Chicago): proxy for Tom Walsh (D- Ottawa)]*			
			* indicates sponsor of legislation

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For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

**References:** 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil In Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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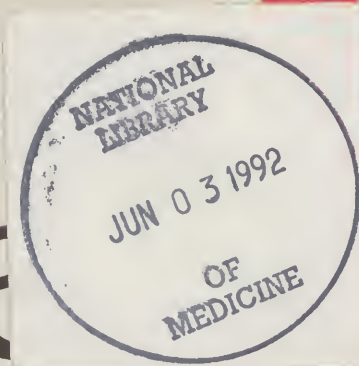
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# Illinois Medicine



ISMS president... profile of the new

May 22, 1992

ILLINOIS STATE MEDICAL SOCIETY

## Universal health foes, advocates face off

### *Universal health bills do not fit ISMS reform principles*

by Tamara Strom

UNIVERSAL HEALTH bills before the Illinois General Assembly do not measure up to organized medicine's principles of health care reform, said Illinois State Medical Society President Arvind K. Goyal, M.D., during a May 11 press conference at the state Capitol.

H.B. 2774 and S.B. 1495 – which call for a single-payer, government-run health care delivery and financing system for Illinois – dismantle the current system, ignoring its strengths, Dr. Goyal said. "While the current system is not without fault, it has provided the best medical care in the world to millions of patients for decades," he told reporters. "It would be a horrible mistake to scrap it for a system that would ration care and stifle medical technology."

The 10 principles adopted as ISMS policy by the House of Delegates last month provide a framework for discussion and can be used to rate reform measures as they are proposed, Dr. Goyal explained. The thrust of the principles is building on the existing system, while strengthening Medicare and Medicaid and revamping in-

(continued on page 13)



Ron Ackerman



### Both sides of the issue

The week of May 11 was a busy one for opponents and supporters of the two universal health care bills in the Illinois General Assembly. Illinois State Medical Society President Arvind K. Goyal, M.D., (left) explains to the Springfield press corps May 11 why a single-payer health system would lead to rationing of care. Two days later, about 200 universal health care supporters staged a rally at ISMS' Springfield offices to voice anger at the Society's opposition to H.B. 2774 and S.B. 1495.

### *Rally draws 200 in support of universal health care*

by Tamara Strom

PLANTING CARDBOARD tombstones on the front lawn of the Illinois State Medical Society's Springfield offices, more than 200 supporters of universal health insurance accused

the Society of blocking health care reform in Illinois during a May 13 rally.

The crowd marched, chanted pro-universal health care slogans and listened to speakers for more than an hour. Among the "epitaphs" on the tombstones gracing

the Society's lawn were "R.I.P. midwifery," "R.I.P. quality of care," and "R.I.P. Medicare mandatory assignment."

Using bullhorns to ensure their messages reached into the second floor ISMS offices, representatives from

several consumer advocacy and union groups extolled the virtues of a single-payer, government-run system and blasted ISMS' opposition to such a program. Speakers said they are opposed to what they called a "two-tiered health care system," adding that a single-payer system would eliminate this "social and moral injustice." They called for passage of two bills – H.B. 2774 and S.B. 1495 – now in the General Assembly that would establish a single-payer, state-administered health care delivery and financing system for Illinois.

"The issue is out in the open now and people are ready for it," said Sam Vasquez, of the Illinois State Council of Senior Citizens Organizations, about the call for national health insurance. Vasquez also cited ISMS' past opposition to proposed legislation on mandatory assignment for Medicare that he said would have "contained the enormous rising costs of health care."

Rally leaders said they attempted to arrange a meeting with ISMS leaders about universal health to coincide with the demonstration, but claimed they received no response to their registered

(continued on page 13)

### *Task force nears completion of AIDS recommendations*

by Anna Brown

DESPITE MISSING its April 1 deadline, Gov. Jim Edgar's Task Force on AIDS in Health Care is very close to presenting its final recommendations to the governor. With only a few points left to iron out, the group will meet at least one more time, task force Chairman

Nestor Ramirez, M.D., told *Illinois Medicine*.

The task force has been working since November 1991 to draft recommendations for implementing S.B. 999, the compromise HIV-AIDS notification law passed last summer. Engendered by reports of a Nokomis dentist who died of AIDS, S.B. 999 has been described as an imperfect but necessary piece of compromise legislation designed to address public concerns over the transmission of HIV and AIDS in the health care setting.

The plan now is to add a fiscal note to the nearly completed document, Dr. Ramirez said.

To date, the task force recommendations have not strayed far from guidelines issued by the U.S. Centers for Disease Control last year. The group has tentatively adopted the CDC's November 1991 guideline

draft as part of its recommendation to the governor until a final draft is available for review.

Dr. Ramirez emphasized that all task force recommendations are scientifically based, using peer-reviewed data from institutions such as the CDC, National Institutes of Health and the *New England Journal of Medicine*. He described what he considered the task force's four key scientific conclusions:

- The risk of HIV transmission from health care workers to patients is "extremely low to non-existent";
- "Patients have no valid health interest" in the identity of a health care worker involved in an exposure incident;
- "Health care workers will submit voluntarily to a review panel" if they are found to be HIV positive and have performed high-

(continued on page 10)

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## Third UI student dies from meningococemia

Despite a campus-wide vaccination campaign, a third University of Illinois at Urbana-Champaign student died May 5 of meningococemia, a blood infection caused by the same bacteria that induces meningitis. The student, a 19-year-old sophomore from Wheaton, was one of more than 18,500 UI students immunized against the disease. The university began the immunization effort in February after consulting with the U.S. Centers for Disease Control when seven students contracted the disease in less than a year.

According to the CDC, the vaccine

is successful in providing immunity to meningococcal disease in about 85 percent to 95 percent of those inoculated. Students received the free vaccine at the university health center through the end of the spring semester, May 16. According to UI officials, the university is still reviewing recommendations it will make to current students, as well as whether incoming freshmen should be inoculated before they arrive on campus in the fall.

## Breast cancer trial recruiting 16,000

Physicians with female patients at an increased risk for breast cancer can

offer these women an opportunity to participate in the first large-scale breast cancer prevention study. At more than 270 sites in the United States and Canada (including 20 throughout Illinois), 16,000 women over age 35 will be followed for five years to determine if the anti-cancer drug tamoxifen can actually prevent cancer in women who take it in prophylactic doses.

Tamoxifen is one of the most widely prescribed cancer treatment drugs; increasing evidence suggests the drug can actually prevent cancer in some patients, according to the National Cancer Institute, sponsor of the trial. The Breast Cancer Prevention Trial will be a random, double-blind study, with half of the participants taking twice-daily tamoxifen doses and the other half taking a placebo. Neither the patient nor her physician will know which she is taking.

To be eligible for the study, patients must have a higher than normal risk for contracting breast cancer. Risk factors include relatives with the disease, a history of breast biopsies and a previous diagnosis of atypical hyperplasia of the breast. To participate, women must receive a mammogram, complete gynecological exam and blood work before en-

## Questions on CLIA and OSHA?

Physicians with questions about complying with the Clinical Laboratory Improvement Amendments of 1988 and the U.S. Occupational Safety and Health Administration bloodborne pathogens standard are urged to call the Illinois State Medical Society's department of medical services at (312) 782-1654. ▲

tering the study. Women can receive these services from their own physicians. Exams and tests performed within the last six months will qualify.

The study is being conducted by the National Surgical Adjuvant Breast and Bowel Project, a group of 6,000 cancer researchers at medical centers around the country. The principal investigators in Illinois are the Illinois Cancer Council, Illinois Masonic Medical Center, Rush-Presbyterian-St. Luke's Medical Center and the University of Chicago Hospitals.

For additional information or to participate in the study, call (800) 4-CANCER. ▲

— by Tamara Strom

## Corrections and clarifications



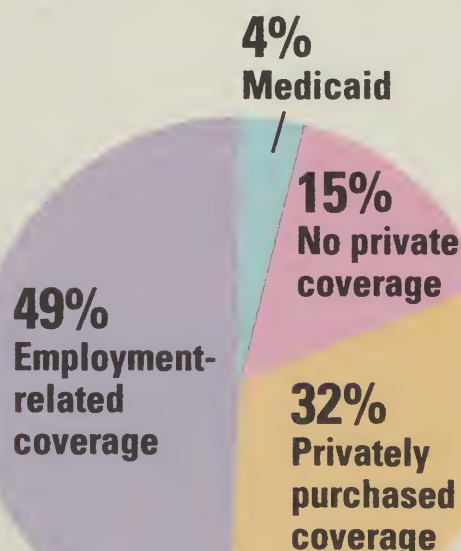
In the annual meeting photo coverage on pages 12 and 13 of the May 8 issue of *Illinois Medicine*, Morgan M. Meyer, M.D., (back row, third from left) was omitted from the photo of past ISMS presidents.

In the same issue, page 14, David B. Littman, M.D., ISMS secretary-treasurer, was incorrectly identified. Dr. Littman practices internal medicine in Highland Park. *Illinois Medicine* regrets the errors. ▲

## Physician Facts

### Health insurance coverage of retirees age 55 or older, 1987

Retirees age 55-64 who have neither Medicare nor employment-related or other private health insurance coverage are especially vulnerable to the risk of high out-of-pocket health care expenses. Also vulnerable are retirees over 65 covered by Medicare who still face out-of-pocket costs for Medicare deductibles. Following are some statistics on insurance coverage of retirees age 55 or older in the United States.



Source: "Retirees: Medicaid and Other Public Health Insurance Coverage," published by the U.S. Department of Health and Human Services; Agency for Health Care Policy and Research.

## ISMS, AMA protest TV program on international medical schools

by Kevin O'Brien

REJECTING THE implication that international medical graduates practice inferior medicine, the Illinois State Medical Society and the American Medical Association have vigorously protested a recent segment of the new program "Dateline NBC."

After receiving several complaints from Illinois physicians, ISMS President Arvind K. Goyal, M.D., wrote to Robert C. Wright, NBC president and chief executive officer, demanding an "on-air" apology for the "distasteful and misleading" program. The AMA protested to Jeff Diamond, executive producer of "Dateline NBC," with a copy sent to Wright. Dr. Goyal's letter follows.

Dear Mr. Wright:

I write to you on behalf of 18,000 members of the Illinois State Medical Society to protest your April 21, 1992, "Dateline NBC" segment on "diploma mills" in offshore medical schools in Mexico and the Caribbean. Your program did its viewers a great disservice by implying that all foreign-educated physicians were rejects of U.S. medical schools, inferiorly trained, and "dangerous." Nothing could be further from the truth.

Your program defied the public trust by failing to research and include information regarding requirements of internship, residency and licensure, all of which insure the qualifications of all licensed practitioners, no matter which medical school they attended. You totally ignored the requirements of specialty board certification, which offers further confirmation of competency after extensive testing, a path adopted by the majority of physicians both American and foreign trained.

You also chose to hold a unilateral trial of a professional liability case on television, and then reach your own conclusions. In effect, you precluded a fair court trial of a case that is still pending.

Many good physicians who practice in Illinois and went to medical schools in the U.S.A. and abroad found your program distasteful and misleading.

On behalf of those physicians whose abilities were impugned by your distortions, I suggest an "on-air" apology is due. I sincerely hope your future programming will be based on facts, not fiction.

Sincerely,  
Arvind K. Goyal, M.D.  
President

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# AMA ethical report provides blueprint for physician self-referral

SET AGAINST A backdrop of intense debate over universal health insurance, the issue of physician self-referral has caught the attention of Illinois lawmakers during the spring legislative session.

Legislation pending in the Illinois General Assembly would prohibit physicians from referring patients to health care facilities in which the doctors have a financial interest. One bill cleared the Senate Committee on Consumer Affairs on April 29. As originally drafted and proposed by Sen. William A. Marovitz (D-Chicago), S.B. 2201, the Physician Self-Referral Act, would levy stiff penalties for violations and would precipitate disciplinary action by the Illinois Medical Disciplinary Board.

S.B. 2201 calls for civil penalties of between \$20,000 and \$70,000 per violation and allows physicians only one year to divest their financial interest in facilities to which they refer patients. The original bill is supported by the Illinois Radiological Association, which assisted in its writing.

Self-referral legislation introduced this session in the House by Rep. John S. Matijevich (D-Waukegan) cleared the House Health Care Committee April 30. Sponsors of both the Senate and House bills have agreed to work in good faith with the Illinois State Medical Society on amendments to the legislation addressing the self-referral issue. At press time, ISMS was working to craft such amendments, but no final drafts had been completed to propose to the bill sponsors.

"Unfortunately, the public sees only the potential negative implications of physicians referring patients to facilities they own simply as a matter of increasing profits," said ISMS President Arvind K. Goyal, M.D. "But we know that the vast majority of physicians who have financial stakes in health facilities want to provide convenient access to high-quality medical services for their patients. Particularly in medically underserved areas of the state, such as rural communities, the benefits of having a physician-owned facility far outweigh the drawbacks of leaving that community without access to those services."

Responding to the legislative focus on self-referral, the ISMS Executive Committee May 13 approved a recommendation from the Society's Third Party Payment Processes Committee that ISMS seek introduction of an amendment to self-referral legislation in the General Assembly. The American Medical Association's self-referral ethical guidelines, published in the May 6 issue of the *Journal of the American Medical Association*, should serve as guides in constructing amendments to the bills, the Executive Committee decided.

Key points of any potential ISMS-backed legislation should include lesser financial penalties per violation and an extension of the deadline for physicians to divest their holdings; both concepts are recommended by the AMA.

To ensure access for medically underserved communities, the Executive Committee said a mechanism should be established to grant exemptions permitting referrals to fa-

cilities in which physicians have financial interests. As stated in the AMA guidelines, appropriate exemptions could be granted if a demonstrated need exists in the community for the facility and alternative funding options are not available.

Physicians are often the only community residents with sufficient knowledge, interest and resources to undertake the risk of building expensive health care facilities, such as clinical laboratories or MRI centers. Although the Executive Committee discussed giving authority for granting waivers to the appropriate state agency, such as the Illinois Health Facilities Planning Board, it underscored the need for

such exemptions particularly in downstate communities with limited referral options. The Executive Committee suggested this case-by-case approach would be more effective than simply "grandfathering" all existing ventures.

## AMA guidelines stress appropriate referrals

The AMA report indicates physicians may refer patients to a health care facility in which they have a financial interest if the facility is within their office practice and the physician directly provides care or services at the facility.

The revised AMA guidelines also say that physicians may invest in and refer patients to an outside facility

whether or not they provide direct care or services at the facility, if a demonstrated need exists for the facility and other financing sources are not available. If such need is demonstrated, the guidelines list an additional 10 requirements the physician and facility must adhere to, including a ban on generating referrals as a condition of continued ownership. Physicians also must disclose their investments in the facility to all patients being referred.

Physicians who entered into financial arrangements with health facilities before these revised guidelines were issued should re-evaluate their situations and comply with the new guidelines to the fullest extent possible, the AMA recommends. ▲

## Blue Cross Blue Shield REPORT FOR *Illinois Physicians*

### "PAM" & LASER INTERFEROMETRY TO BE INCLUDED IN EYE EXAM/VISIT

In the past, both "PAM" (Potential Acuity Meter, HCPCS Code W9246) and Laser Interferometry (HCPCS Code W9248) have been payable separately, based on diagnosis.

EFFECTIVE JULY 1, 1992, these 2 tests will be considered part of an eye examination and NOT billable separately. This change is based on instructions from Health Care Financing Administration; they found that other Medicare carriers include these 2 tests as part of the eye examination. In striving for national uniformity, we will no longer pay separately for "PAM" or Laser Interferometry. Medicare's Approved Amounts for the eye exam codes (92002-92014) will be adjusted accordingly.

This new guideline applies to any 1992 date of service billed July 1, 1992 or later.

### CORRECTION – HCFA-1500 INSTRUCTIONS

Detailed instructions for the completion of the new HCFA-1500 claim form were included in the March 1992 Medicare B BULLETIN. Refer to Item #24B-Place of Service. A physician CANNOT bill for a laboratory service purchased from an independent laboratory--the laboratory must bill for the service they provide. CROSS OUT the statement "If the physician is billing for a laboratory service purchased from an independent laboratory, the code for 'Independent Laboratory' (81) is used" -- this statement is INCORRECT.

### QUESTIONS & ANSWERS

The following are a few common questions that have been asked of our Telephone Unit in Marion:

Q - What is the difference between a Nursing Facility (Procedure Codes 99301-99313) and a Domiciliary Care/Rest Home Facility (Procedure Codes 99321-99333)?

A - A Nursing Facility (formerly called a Skilled Nursing Facility or SNF) provides a 24-hour group living & learning environment staffed with medical & professional personnel. A Domiciliary Care/Rest Home Facility offers room, board, & other personal assistance services, generally on a long-term basis, but do not include medical services of any kind.

Q - If I haven't heard on a Medicare claim, should I just automatically refile it?

A - No. First check on the status of the claim by calling our Provider HotLine (1-618-997-3190). If you are an electronic biller, use the Professional Provider Terminal Network (PPTN) to check the status of your claim.

Q - What does Medicare consider to be a "surgical procedure"?

A - CPT procedure codes 10000 thru 69979 are considered surgical procedures and are specifically listed in the "Surgery" chapter of the CPT Coding Manual. Also, the following procedure codes are considered surgical procedures: 92975, 92977, 92982 thru 92990, 93501 thru 93536, 92541 thru 92553, 93561 & 93562, 93600, & 93660. Refer to the 1992 CPT Coding Manual for further explanation.

(5/22/92)



## Editorial

# Begin at the beginning: 1, 2, 3 ...

**T**he ISMS House of Delegates has provided a very valuable tool to all interested parties in the national debate on health care reform. By endorsing Unfinished Business Report D at the recent annual meeting, the delegates established official policy for health care reform.

For the past two weeks, leaders of the state medical society have been visiting with the Illinois media to share these guidelines. Our message has been: Health care reform plans that don't measure up to these principles could be dangerous to your health.

1. **Any program of reform should build on the strengths (and correct the weaknesses) of the current health care delivery system.** Throwing out the baby with the bathwater may be a cliché, but that doesn't mean it doesn't apply. Let's not dump a system that works 85 percent of the time for a system that's slowly falling apart in other countries.

2. **The current combination of public and private funding for health care should be continued.** See above. Should we entrust our health care system solely to the same people who gave us Pentagon-style spending?

3. **Everyone should have equal access to a basic package of health care services, including preventive care.** Not everyone needs ultrasophisticated or exotic care, but no one should be denied the care that forms the basis of good health.

4. **The insurance industry should be reformed to increase availability and affordability of health insurance.** Guaranteed issue and guaranteed renewal are the key phrases here; increasing the number and size of risk pools will help the industry stay competitive.

5. **Medicare should be expanded.** There are seniors who fall through the cracks now – they shouldn't.

6. **Medicaid should be restructured.** This program should be federally mandated but state managed; and states should have the freedom to attack the problem of providing care to their poorest citizens with all the creativity and innovation they can muster.

7. **We must adequately fund public and private health care programs, both now and in the future.** Private health insurance needs to be affordable. Public programs need to have our commitment that realistic and adequate funding will be budgeted every year to help us keep the promises those programs make.

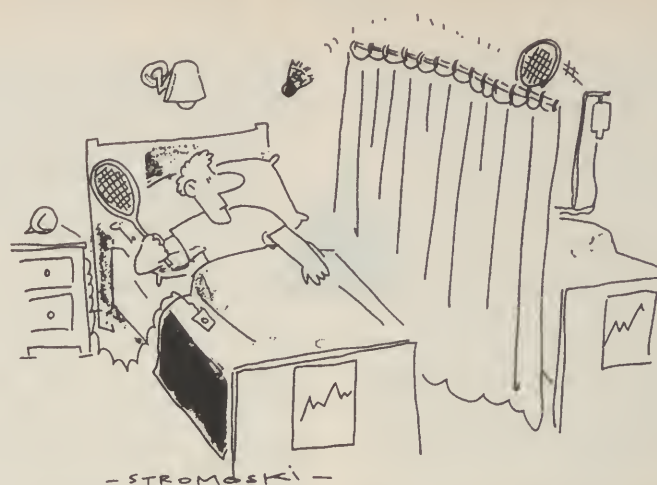
8. **Tort reform is an essential component of health care reform.** In Illinois, that means a cap on non-economic damages.

9. **Administrative costs, including paperwork, should be reduced.** Using electronic claims processing will save paper, wear and tear on the doctors' staff, and dollars. So will standardizing processes, definitions and requirements in UR.

10. **Increased health education can result in decreased health care costs.** Prevention costs far, far less in the long run than cure. Substance abuse, diet and nutritional factors, violence, and tobacco abuse are all factors in poor health that can be corrected with education. It's never too late to start.

There it is, elegant in its simplicity, the framework on which to build a program that provides access, promotes health, pays fairly and works. In the weeks ahead you'll be hearing more about these guidelines – in these pages and, we hope, in the pages of your local paper.

Sometimes something as plain as A, B, C or 1, 2, 3 is all you need to start to make sense of a complex problem. The House of Delegates has given us a tool – let's at least give it a try. ▲



## President's Column

*A stitch in time saves nine*

## My case for defining a basic benefits package



Arvind K.  
Goyal,  
M.D.

The man informed the insurance agent he wished to have his life insured. "Do you drive a car?" asked the agent. "No," replied the man. "Do you fly a plane, or sail a boat?" was the next question. "Never been interested." "Well, I'm very sorry sir," the life insurance agent said firmly, "We are in business to cover the risks, but we don't insure pedestrians."

A pedestrian can still get health insurance these days, as long as there are no pre-existing conditions and if money is no object! But what gets covered may be the best kept secret! I once remember getting some calls on behalf of my patients from a utilization review agent working for an insurance company and seeking justification for a planned procedure. I and my patient found later, the insurance contract specifically excluded coverage for that procedure. That fact was previously unbeknown to the patient. Shouldn't the "truth in disclosure" and "informed consent" principles apply here? Don't these consumers deserve to be educated about their insurance policies before they have a catastrophic experience?

I noticed too that many of the 40 or so health care reform "transform" proposals currently on the table, talk about provision of basic or minimum insurance benefit package. Nowhere is that package defined! Some things are better not clarified. That way people don't get confused. The less they know, the happier they may be! For a while anyway, that is, until they get sick!

But then I thought. A standardized minimum insurance benefit plan could be developed. Indeed, that was one of the recommendations from your House of Delegates meeting this past April. That could provide a firm benchmark for patients and their healers to know what the rules are. The fine print in insurance policies would no longer

be a required reading. More people would be less confused.

Then it occurred to me. That sounded too good to be true. Nothing is that clean anymore. All peoples' needs are not the same. Luxury to one may be absolute necessity to another. Health care rationing may become too easy to implement. Some powerful special interest groups may successfully lobby in an election year for some expensive "ornament" on a "basic" Christmas tree. Those mandated add-ons may not come cheap and may only benefit a handful. And that could make the insurance policy out of pocket and out of sight!

A carefully developed plan could do much to bridge some gaps in existing insurance policies, expand access to care while controlling the costs for everybody. And for those with different priorities, "frills" could always be offered as options at added cost.

As I sat down to prepare a list of items that ought to be included and those that didn't belong, my bias toward my specialties of family practice and public health showed. This list became awfully long, something that your editors would not accept. And there were many items in between – organ transplants and implants, chronic dialysis, chronic ventilator therapy, residential and custodial care. Those items, that I wasn't sure, our "society" would want to cover. And the real question, could our society afford to pay for those? And I bet there were items I didn't think of. Or I just didn't know.

Should we start our "fires" and debate, now, to come up with such a list? I think that time is here. ▲

ARVIND

Arvind K. Goyal, M.D.  
President

# Illinois Medicine

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## Guest Editorial

## Universal health: an excellent beginning



by Quentin D. Young, M.D.

In the April 24 issue of *Illinois Medicine*, the leadership of the Illinois State Medical Society denounced the Universal Health Care Act pending before our state legislature. Their opposition to universal health reform is deplorable. At a time when our profession should be leading the movement for urgently needed changes in health care access and financing, we are cast in the villain's role by our shortsighted spokesmen. We are witnesses to the widespread dissatisfaction among physicians who are suffering along

*"A national health insurance program can eliminate micromanagement of medical practice by private insurance bureaucracies, while the profession itself assures quality based on outcome research, peer review and public education."*

with their patients. Doctors are appalled at the millions of Americans without protection against the high costs of health care. We are saddened at second-class care for Medicaid patients, people in rural Illinois or people from minority backgrounds. We despair that our uninsured patients are dumped or subjected to "wallet biopsy" because of the economic realities in contemporary health services.

In response to public concern about these problems, political leaders have begun to address the fundamental flaws in our health care system. As I write this, the Universal Health Care Act has received "do pass" votes from the respective health committees of the Illinois House of Representatives (H.B. 2774) and Senate (S.B. 1495). While it is not certain the bill will actually prevail in both chambers, let alone avoid or overcome a veto from Gov.

Edgar, this stunning response to the surge in popular demand warrants the thoughtful attention of Illinois physicians.

The main opposition to fundamental health care reform is from the powerful health insurance lobby and the leadership of organized medicine. Since a comprehensive national health insurance program eliminates the need for the 1,500 health insurance companies in place today, their bitter counterattack is understandable, though lamentable. However, American physicians have much to gain under a national health program. Doctors, more than any other group, know from daily tribulation the bureaucratic and parasitic role the insurance companies play. By rational standards, we can only envy the hassle-free professional transactions of our Canadian colleagues. Their patient fees are paid in full every two weeks based on a computerized billing to the provincial Ministry of Health, which takes two hours of a clerk's time. Testimonials from Canadian physicians, in addition to well-documented research, point to a high level of satisfaction with the practice of medicine in Canada: 85 percent of Canadian physicians support government-funded national health insurance. Professional autonomy is enhanced by the elimination of micromanagement by third party payers, allowing doctors to focus on medicine, rather than business. Sadly, spokesmen of organized medicine in the United States have been among those who misrepresent and distort the Canadian health system's many achievements, and have therefore contributed to the stagnation of our own system.

We know that America's physicians have the skills and motivation to serve all the nation at the best level, assisted by the vast talented health workforce and the most magnificent hospital and technical resources already in place. We know the health system can work for everyone with rational allocation and planning. Of course, the nation must avoid "government medicine," which could be as onerous as the private arrangement smothering us today. By placing decision making at the state and local level, we can nurture, rather than circumvent, our democratic tradition of governance. A national health insurance program can eliminate micromanagement of medical practice by private insurance bureaucracies, while the profession itself assures quality based on outcome research, peer review and public education.

These days, there are innovative and constructive initiatives from the American College of Physicians, the American Academy of Pediatrics and the Physicians for a National Health Program, among others. Can we hope the Illinois State Medical Society will at long last offer a constructive approach? I suggest support of H.B. 2774 and S.B. 1495 would be an excellent beginning. ▲

*Dr. Young, an ISMS member, is chairman of the Chicago-based Health and Medicine Policy Research Group.*



*Illinois Medicine welcomes letters on topics of interest to our readers. Write us at Letters to the Editor, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602 or FAX (312) 782-2023. Letters of any length will be considered for publication, but we reserve the right to edit for space.*

## Go after the plaintiff lawyers

Congratulations on your publishing the recent article on Al Hofeld and your past article on Phil Corboy. We need a repetition of such articles with almost every issue of *Illinois Medicine*. The medical profession has laid back and allowed the lawyers to say anything they wish without having an aggressive approach against them.

I fault the American Medical Association for its passive attitude toward malpractice [plaintiff] lawyers. Maybe *Illinois Medicine* can carry the torch, and other state medical societies will read what you have published and they too will awaken.

Arthur W. Peterson, M.D.  
Elmhurst

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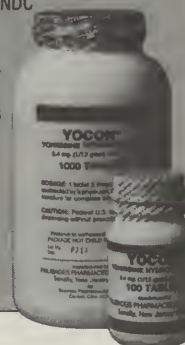
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## References:

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# Anesthesiologists pave route to loss reduction

by Anna Brown

ILLINOIS anesthesiologists can congratulate themselves on a job well done – and can look forward to lower malpractice insurance premiums for 1992-93. Because of risk prevention action taken over the past decade by anesthesiologists nationwide resulting in improved patient care and better loss records, the Illinois State Medical Inter-Insurance Exchange has lowered the specialty from Class 4 to Class 3 for 1992.

*"The mode of the anesthesiologist is vigilance ... Qualified anesthesia personnel must be present to observe the patient every second."*

"Malpractice insurance companies across the country have lowered premiums for anesthesiologists because of the improved quality of care in recent years," says Harold L. Jensen, M.D., chairman of the Exchange Board of Governors. "In Illinois, the Exchange annually reviews loss experience, and each year we are pleased to see consistent positive improvements for anesthesiologists. Such improvements lead to significant premium reductions."

"In the early 1980s, anesthesiologists were in one of the highest rated classes," says Henri S. Havdala, M.D., an Exchange Board member who also sits on the Risk Management Committee. "Since then they have steadily moved down. In 1991, the specialty received an 11 percent rate premium reduction, and in July 1992 they will move down to Class 3."

The main reason for the specialty's improved rating is the implementation of strict monitoring standards by the American Society of Anesthe-

siologists, which were adopted throughout the United States. The ASA also conducted studies of closed liability claims to determine what improvements anesthesiologists could make in their practices.

In the mid 1980s, the national Anesthesia Patient Safety Foundation began an educational campaign targeting anesthesiologists, including a quarterly newsletter, seminars and panel discussions.

"The foundation gathered people from all over the country to adopt practices that will eliminate or minimize causes of anesthesiology mishaps," says Dr. Havdala, who chaired the Exchange Anesthesiology Subcommittee in 1991. Like the ASA, the Anesthesiology Subcommittee reviewed more than 50 closed claims involving anesthesiologists to identify common risks and problems that could lead to claims. This information has been compiled into a new Exchange brochure, "Exploring Liability Issues in Anesthesia," that will be mailed to Illinois anesthesiologists at the end of May.

"The mode of the anesthesiologist is vigilance," says Dr. Havdala, describing the necessity of the ASA standards. "The first standard is patients shall never be left alone under anesthesia. This seems very basic, but it sometimes happens. Qualified anesthesia personnel must be present to observe the patient every second to avoid brain damage."

The use of monitors not commonly used 10 years ago, such as pulse oximeters and capnometers, have also significantly improved the specialty's loss experience, Dr. Havdala says. "Such monitors have been very valuable in ensuring the correct position of endotracheal tubes. Misplaced tubes have caused the highest damages against anesthesiologists. Monitors also can detect problems at an early stage before serious damage can occur."

The Anesthesiology Subcommittee found that complications resulting in claims can occur at every stage of

## Exchange first quarter invoices mailed May 18

PHYSICIANS insured by the Illinois State Medical Inter-Insurance Exchange began receiving their first quarter invoices for the 1992-93 policy year May 18. A new billing schedule, effective July 1, advances by five days the dates for termination notices and cancellation for non-payment. The changes are designed to improve the premium collection process and save administrative costs.

Under the new schedule, quarterly invoices will be mailed about seven weeks before the due date. Termination notices will be mailed five days before the due date to policyholders who have not paid by that time. *Policies will be canceled on the cancellation date if the invoice remains unpaid.* To be reinstated after the cancellation date, a policyholder must be approved by Exchange underwriters.

1st quarter: July 1-Oct. 1, 1992	Issue date	Premium due date
Renewal invoice	May 18	July 1
Termination notice	June 26	July 1
Cancellation for non-payment	July 10	
2nd quarter: Oct. 1, 1992-Jan. 1, 1993	Issue date	Premium due date
Renewal invoice	Aug. 10	Oct. 1
Termination notice	Sept. 25	Oct. 1
Cancellation for non-payment	Oct. 9	
3rd quarter: Jan. 1-April 1, 1993	Issue date	Premium due date
Renewal invoice	Nov. 9	Jan. 1
Termination notice	Dec. 28	Jan. 1
Cancellation for non-payment	Jan. 11	
4th quarter: April 1-July 1, 1993	Issue date	Premium due date
Renewal invoice	Feb. 8	April 1
Termination notice	March 26	April 1
Cancellation for non-payment	April 9	

treatment. The group identified common problems during the pre-anesthesia evaluation, perioperative monitoring and post-anesthesia evaluation and treatment. In addition, anesthesiologists are not free from problems prominent in other specialties, such as lack of documentation, altered records and poor communication, the subcommittee found. Risk management recommendations heavily based on the standards adopted by the ASA are outlined in the Exchange's brochure.

"Application of these and other standards have led to a reduction of suits," says Dr. Havdala. "By minimizing the causes of mishaps, anesthesiologists can work toward even better loss records and overall improved, quality care." ▲

## Risk management speakers, seminars available

- The Illinois State Medical Inter-Insurance Exchange is providing speakers to address clinics, hospital medical staffs or local medical societies on risk management topics. A physician speaker can address general risk management issues such as documentation, patient communication and other loss prevention strategies, as well as specialty-specific concerns. Programs for office staff are also available.
- The Exchange is currently offering two risk management seminars on a continuing basis.

"Loss Prevention Strategies for Physicians" is a three-hour program presented by practicing physicians and a defense attorney. Topics include patient communication, medical record documentation and defense strategies.

"Taking Control: Managing Your Malpractice Suit" is a two-hour program for physicians who have been named in a malpractice suit. A physician, a defense attorney and an Exchange professional liability analyst describe the litigation process from summons and complaint through trial, and help physicians prepare for the emotional ramifications of being sued. Spouses are also welcome.

For more information on seminars or speakers, please call (312) 782-2749, ext. 1394, or (800) 782-ISMS. ▲



**Exchange seminar focuses on early cancer detection** Physicians (right) attending the Exchange risk management seminar "Malpractice Dilemma: Focus on Cancer Detection and Diagnosis" April 29 in Oak Brook heard speakers including Alfred J. Clementi, M.D., (left) address the screening and treatment of various cancers. More than 350 participants have attended the seminar, which has been held three times. At least one more seminar will be scheduled in the Rockford area. ▲



# New ISMS president considers patient contact most rewarding

by Kathy Meyer

ARVIND K. GOYAL, M.D., did not grow up wanting to be a physician. And he certainly never dreamed of becoming president of the Illinois State Medical Society, a position he assumed in April. Two events changed his mind – and his life.

What convinced Dr. Goyal to pursue a medical career was the tragic death of a little brother. Born in an industrial town in India, Dr. Goyal was away attending his first year of high school when a brother sustained severe burns in an accident and died shortly thereafter because expert medical care was not available. From that point on, Dr. Goyal knew he wanted to become a physician.

"We all look for careers where we can make a living and satisfy our own needs – by that I mean our emotional and inner needs," Dr. Goyal told *Illinois Medicine*. In that respect, being a physician is "a very satisfying job. You have people who count on you, who rely on you," Dr. Goyal said. What he prizes the most is his patients' appreciation. "They say, 'Thank you.' I don't know where else there's that much reward," he said.

After receiving his medical degree at Government Medical College in Patiala, India, Dr. Goyal participated in a rotating internship and then short residencies in surgery and general medicine while trying to decide on a specialty. He chose family medicine when he was accepted into the first family practice residency program at Cook County Hospital in Chicago in 1972.

Dr. Goyal joined ISMS in 1974 to learn more about the practice of medicine; initially, he said, he had little interest in becoming active in organized medicine. A telephone call in 1980 from the president of the Irving Park Branch of the Chicago Medical Society changed that. The branch had an open position for an alternate councilor and its treasurer, and Dr. Goyal fit the bill.

"It's almost addictive," Dr. Goyal said about his activities in organized medicine. Today, he belongs to at least 10 medical organizations, including the Illinois Academy of Family Physicians, American Public Health Association and Indian Medical Association. He is a fellow of the American Academy of Family Physicians and of the American College of Preventive Medicine.

Dr. Goyal also chairs the Illinois State Medical Licensing Board, serves on the Illinois Department of Public Health Acute Care Task Force and remains active in the Chicago Medical Society, where he served as president from 1990 to 1991. At the national level, he is an Illinois delegate to the American Medical Association.

"I think the most important thing we learn as physicians is to manage time effectively," Dr. Goyal said. To help manage his limited time, Dr. Goyal has prioritized everything in his life, from the most important to the most trivial.

Topping Dr. Goyal's priority list are his family and his patients. He is adamant about spending time with his family – wife Renu and daughters Sapna, 16, and Saya, 10 – and makes

a point to attend PTA meetings and his daughters' school and extracurricular functions. He also has no qualms about seeing patients late on weeknights or on Sundays if he's been away from the office during normal business hours. "You do what you have to do ... and make the best of the time you have," he said.

Dr. Goyal looks ahead to his year as ISMS president "to use the Society to its maximum potential" in protecting and improving public health and fully representing Illinois physicians before the government, the public and regulatory agencies. "We do the best we can for our own profession ... for public health," he said. ▲

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ISMS President Arvind K. Goyal, M.D., with his family (from left): daughter Sapna, wife Renu and daughter Saya. Dr. Goyal says appreciation from patients is what he prizes most about his career in medicine.



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# Auxilians celebrate past, make commitment to future

by Rachel Brown

THE ILLINOIS STATE Medical Society Auxilians attended educational workshops on family violence, the importance of volunteerism, tips for a successful Auxiliary and the politics of health care reform during their annual meeting April 8-10 in Oak Brook.

The 64th Auxiliary annual meeting, titled "Celebrate the Past, Commit to the Future," allowed Auxiliary members and guests to share successful programming ideas of the past and encourage greater member participation in the coming year.

"We are an organization that gets things done," said newly elected Auxiliary President Carol Gapsis, of Morton, in her inaugural address. "We have a tremendous desire to make things happen, to move ahead, to serve more people, to become the best that we can possibly be to help improve and change the world around us."

In her year as president, Gapsis intends to increase legislative education efforts for Auxiliary members. "The Auxiliary's focus this year will be on legislation, because it is important that we make our voices heard in Springfield," she said.

One educational workshop at the annual meeting, "The Politics of Health Care Reform," featured Doug Richardson, legislative adviser to the Winston and Strawn law office in Washington, D.C. Richardson discussed the federal legislative process, the difficulty in passing health care reform in Congress, and the Canadian and U.S. health care systems.

Kankakee County Auxilian Laura Hays felt Richardson's detailed comparisons of the Canadian and U.S. systems will supply Auxilians with "good ammunition" to use when educating the public on these two diverse health care systems.

The Auxiliary's legislative efforts this year include an education seminar for members and spouses held May 20 in Springfield. The half-day seminar included legislative briefings and information on organizing voter registration drives, said Gapsis.

The Auxiliary also plans to work with the American Medical Association in combating family violence. A workshop on the impact of television violence on children included a video developed by the AMA and a presentation by Marjorie Hogan, M.D., a practicing pediatrician from Minnesota. Gapsis said county auxiliaries will use a shortened version of the AMA video to educate civic and community groups and PTAs on family violence in America.

"Losing the War Against Cancer: Who's Responsible and What to Do About It," was the title of a workshop presented by Samuel Epstein, M.D., professor of occupational and environmental medicine at the University of Illinois Medical Center in Chicago. Dr. Epstein's "extremely provocative" presentation explored the distribution of misleading information on prevention and causes of the disease, said Barbara Newman, Auxiliary third vice president and health projects chairman.

Another goal Gapsis cited is to offer support and encouragement for

Auxiliary members. "Auxilians do such wonderful things in the communities at the expense of [themselves]," Gapsis said. "I want to make sure the county auxiliaries are acting as support groups and meeting the needs of their members."

Another workshop, "Contribution, Leadership and Grace," paired up Auxilians to discuss the importance of volunteerism, acknowledging others for their contributions and using creativity to add a sense of balance to one's life. Robin A. Sheerer, president and founder of a training and consulting firm in Chicago, moderated the discussion.

Afterward, AMA Auxiliary President-elect Priscilla Gerber shared ideas on how to maintain a successful Auxiliary by encouraging voter registration, organizing mini-internship programs and continuing financial contributions toward medical education in communities.

"[In planning the meeting] we tried to offer speakers that would enlighten and appeal to everyone, not just those really involved in the Auxiliary," said Gayle Dustman, Auxiliary immediate past president. "The topics chosen were those that affect each of us on a daily basis."

In other actions, the Auxiliary



The new Board of Directors of the Illinois State Medical Society Auxiliary gathers at its annual meeting April 8-10 at the Oak Brook Hills Resort.

House of Delegates unanimously passed a resolution increasing membership dues by \$5, beginning with the 1993-1994 membership year.

In addition to Gapsis, other officers and district councilors elected were Mindy Chadwick, of Decatur, president-elect; Carolyn Kobler, of Rockford, first vice president; Kathy Kelley, of Mt. Vernon, second vice president; and Barbara Newman, of Quincy, third vice president. Executive Committee elections include Connie Nelson, of Decatur, secre-

tary; and Sylvia Eberle, of Roscoe, treasurer. Three directors were also elected: Gayle Dustman, of Bloomington; Julie Ringhofer, of Belleville; and Diane Gravin, of Metamora.

District councilors serve two-year staggered terms. Molly Flynn, of Chicago, was re-elected Third District councilor. Newly elected councilors include: Dorothy Panepinto, of Springfield, Fifth District; Judy Carney, of Decatur, Seventh and Ninth districts, and Carol Bertrand, of Rockford, Twelfth District. ▲

## National health care reform: Which plan will work?

by Tamara Strom

PHYSICIANS AT THE educational seminar held during the Illinois State Medical Society annual meeting last month left armed with enough facts to enter the health care debate.

"National Health Care Reform: Implications for Managed Care," offered Illinois physicians a thorough look at three major health plans being considered at the national level. A Bush administration health care adviser and a health care consultant explained the fundamentals of single-payer, government-run programs, pay or play proposals and the president's market-based proposal, and how and why each plan would or wouldn't work.

Thomas Scully, who wrote the president's health proposal, acknowledged he was at a disadvantage speaking to a physicians' group since he is a Washington, D.C., lawyer. But, he said, because he has five physicians in his family, he believes he understands the pressures doctors face today.

Scully said the U.S. health care system offers "fabulous services" to patients, but it is "basically broken." With all the clamor on Capitol Hill and around the nation for reform, the system will be altered in the foreseeable future, he said. But, he added, dramatic reform is unlikely this year because 1992 is an election year and a "log jam" of health care proposals exists in Congress. Scully predicted movement on the national level for health care reform "next year, definitely."

He praised ISMS and its leadership for its timely entry into the re-

form debate through the Society's new Washington presence program. "Your leadership is very active at the national level," Scully said. "The medical society has been helpful to us. Your leadership met with [Budget Director] Richard Darman and [White House Chief of Staff] Sam Skinner before we released our plan. We appreciate your open-minded approach."

### Details important

In an atmosphere dictated by politics and rhetoric in which "a lot of bombs are being thrown back and forth — details are what are important," he said. And details are what sets the administration's plan apart from others, Scully noted. "Our plan is more radical than people give us credit for," he added.

Scully explained that the administration's plan advocates universal access to health care but does so in a reasonable, achievable manner. Under the program, every state would establish a basic health care plan. Income transfers — or vouchers — would be used by low-income individuals not covered by Medicaid. These vouchers would be given directly to the patient's providers. Patients would retain freedom of choice in selecting their health care providers, he said, but a stepped-up emphasis on managed care is a focal point of the program.

In addition, insurance companies would be required to offer guaranteed-issue health insurance for the basic health care plan. Premiums would be set through community rating, not risk rating, and no one would be denied insurance because of a pre-existing condition, Scully

said. The plan attains cost containment through forced competition among providers, he noted.

"We're all going to have major reform," he said. "Market reform is the most rational way. Somebody's going to have to figure out where we're going in the next year. [I advise you to] get as involved and educated as you can — it will affect all your lives."

### Winners and losers

Each of the major health reform plans circulating the nation creates "winners and losers" among patients and providers, said health care consultant Jeff Goldsmith, president of Health Futures, Inc. With single-payer or pay or play health care systems, the government will be intricately involved in determining reimbursement rates and price-setting strategies.

The pay or play system, in which employers are mandated to provide health insurance for their workers or pay into a pool so the government can provide the insurance, is a "recipe for the unionization of medical practice," Goldsmith said. Physicians, hospitals and other providers will be forced to negotiate binding collective bargaining contracts with payers. This favors large group practices with more clout and resources to negotiate better rates.

Primary care physicians would fare better under a voucher system such as that proposed by the Bush administration, he said. And while he does not advocate a single-payer system, he said, several segments of society would benefit under such a plan. Chief among these would be large employers who "gave away the



# Employee of the Month named, service awards given

by Anna Brown

IN AN AWARD ceremony attended by Illinois State Medical Society and Illinois State Medical Insurance Services employees, Susan Wagner was named the Society's Employee of the Month for May.

Wagner received a \$200 award and a recognition plaque. Linda Hudson, ISMS vice president of communications, called attention to Wagner's "unusual insight into the needs of physician policyholders," and her sensitivity to the "unique interrelationships among physicians."

Wagner has been employed by the Society since January 1987, first as policyholders services coordinator and then assistant director of risk management. She was promoted to director of marketing in January 1991. In her current position, Wagner is responsible for promoting membership in ISMS and increasing policyholders in the Exchange, Hudson said. "Susan has consistently anticipated the needs of the physicians with whom she works. She is a team player."

Demonstrating her commitment to her colleagues, Wagner thanked the other members of her department in accepting the award. "We work closely together, and it really is a team effort," she said.

As the Employee of the Month,

store" in the 1970s, promising first-dollar health care coverage and low premiums. "Low-income people on the fringes of society," such as children and other people who do not vote, also would benefit greatly under single-payer. This is why a universal one-payer system ultimately becomes a losing political issue, he said. Politicians would be forced to "raise taxes on people who vote, to cover those who don't."

"Marginal health professionals," such as chiropractors and podiatrists, also win under a universal system, he said. The lobbying process becomes simplified for them to attract support for their expanding functions, because they would not have to lobby lawmakers in all 50 states. This could also create opportunities for increased utilization of allied and marginal health professionals that some believe would save costs.

Goldsmith said physicians are a "vulnerable political interest group" today because it is popular to blame doctors for rising health care costs. He stressed, however, that no one segment of the health care system can bear full responsibility for skyrocketing costs and health care inflation.

After detailing the pluses and minuses of the various plans, Goldsmith said he prefers the president's program – a fact that surprised and pleased Scully. "The reason I like the administration's plan is because it minimizes tinkering on the part of politicians with the health care system," he said. "I hope we survive this season of health care reform with at least our dignity and concern for our patients intact." ▲

Wagner's name will be added to a special plaque in the ISMS reception area listing all award winners.

All permanent, full-time ISMS/ISMIS employees – except those at senior management level – are eligible for the Employee of the Month award. Physicians who wish to nominate a staff member for the award should call the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS.

## Six honored with service awards

During the same ceremony, Exchange Chief Operating Officer Donald Udstuen presented Laura Hutchinson a service award honoring her 15 years with the Exchange,

most recently as an underwriting support supervisor. Hutchinson was unable to attend the ISMS Board of Trustees organization meeting following the ISMS annual meeting, where such awards are traditionally presented. Five ISMS/ISMIS employees were honored with service awards at the April annual meeting: Richard A. Ott, deputy executive vice president, 25 years; Roseanne Christiansen, director of administrative records, 20 years; Cheryl Koos, vice president of planning, 15 years; Linda Hudson, vice president of communications, 10 years; and Diana Role, vice president of management services, 10 years. ▲



Susan Wagner, ISMS director of marketing, was recognized for her service to physicians and teamwork with colleagues.



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# Existing structures can be made accessible without much difficulty

by Kevin O'Brien

"AM I GOING TO have to completely rebuild my office to make it accessible?" asks a physician.

Good question. And one on the minds of many Illinois physicians who must comply with the federal Americans with Disabilities Act.

Fortunately, in most cases, the short answer is "probably not." But the sweeping nature of the law ensures that each and every Illinois physician will have to do something.

The Act, considered the most comprehensive legislation of its kind, goes beyond the provisions of Section 504 of the Rehabilitation Act of 1973, which applies only to federal agencies or private or public agencies receiving federal funding.

The new law, signed by President Bush in July 1990, is designed to protect all people with disabilities from any kind of discrimination and to guarantee them equal access to the provision of goods and services.

A disability is defined as "a physical or mental impairment that substantially limits one or more of the major life activities of such individuals having a record of such an impairment or being regarded as having such an impairment."

## A new 'buzz phrase'

It seems every new statute produces at least one new buzzword, and the ADA is no exception. But, in this case, it is a buzz phrase, and it may prove to be reasonably good news for physicians. Compliance for existing structures need not be prohibitively expensive.

"Existing facilities are required to perform what is called 'readily achievable barrier removal,'" says Lei Ann Marshall-Cohen, legal consultant to the National Center for Access Unlimited, a consulting firm specializing in ADA compliance issues.

Readily achievable barrier removal is a new standard under the ADA, without a counterpart in the state law. "Readily achievable" means easily accomplished 'without much difficulty or expense,'" says Earl B. Slavitt, an attorney with Katten, Muchin & Zavis. "The question then becomes, what is 'without much difficulty or expense?'"

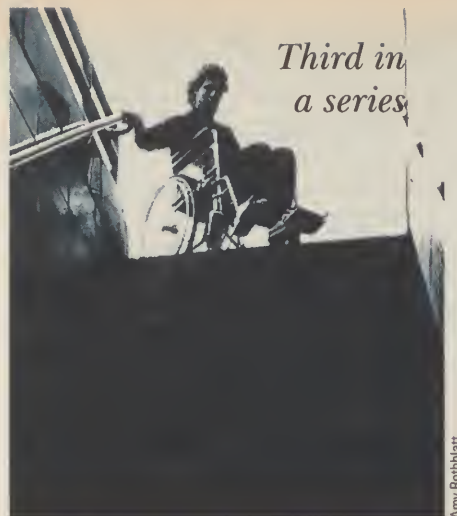
Slavitt says the Act lists five factors to consider when determining what is readily achievable:

- The nature and cost of the action;
- The overall financial resources of the site or facility; number of people employed at the site; effect on expenses and resources; legitimate safety requirements or other impact;
- The geographical separateness and administrative or fiscal relationship of the site(s) to any parent corporation or entity;
- The overall financial resources of the covered entity; and
- The type of operation of the covered entity and the relationship of the site to that entity.

In most instances some degree of modification will be necessary, but that will vary according to the nature of the barrier to be removed, practice size, location of practice and other factors. "It doesn't mean you have to retrofit your facilities," says Marshall-Cohen. "It is very clearly a lesser standard."

Marshall-Cohen says, for example, that what is readily achievable for a single family physician in a rural community in southern Illinois may be a lesser standard than that for a large group practice in Chicago with 35 employees. Wherever the practice, she says, the U.S. Department of Justice recommends four steps in evaluating compliance needs.

First, is the entrance accessible? Can disabled people get in and out? Second, are the services accessible? Once in the facility, can they get into the office or does furniture have to



Amy Rothblatt

be rearranged? Third, are public washrooms accessible? Finally, are other services, such as pay telephones and drinking fountains, accessible?

"The law says you don't have to do everything at once, but you do need to have a plan [to do it] in place," says Marshall-Cohen. She recommends auditing the facility to identify barriers. Then, prioritize according to the Justice Department guidelines and use the "significant difficulty or expense" standard to decide when to do what. For example, a physician might identify 10 barriers, and decide that five barriers can be removed in year one, three in year two and the rest in year three. "You can spread the cost," she says, "but it is clearly an ongoing responsibility."

## Whose responsibility?

Who bears the responsibility for ensuring compliance? Slavitt says that physicians need to determine whether they are owners or operators (i.e., tenants) of their facilities. The responsibilities of each under the Act are determined by their status.

"Title III of the ADA, which deals with public accommodations, really has two general groups that are subject to this, the owner and the operator," Slavitt says. "In this context, the physician may be an owner or operator, or both, based upon his or her relationship to the facility."

All experts suggest that physicians consult attorneys to help determine whether they qualify as an owner or operator. Other factors for determining responsibility include whether the facility is a newly constructed structure, one undergoing substantial renovation, or an existing structure requiring barrier removal.

In addition, the American Medical Association recommends that physicians contact several government offices for information on compliance with the Act. Information on the public accommodations requirements is available from the U.S. Justice Department Office of ADA at (202) 514-0301. Information on the employment provisions can be obtained from the Equal Employment Opportunity Commission at (800) 669-3362. The Architectural and Transportation Barriers Compliance Board, a non-profit group, also publishes compliance guidelines for public accommodations. They can be reached at (800) USA-ABLE. ▲

Next: Providing auxiliary services for disabled patients.

## Task force

(continued from page 1)

risk procedures; and

- Use of universal precautions is the best way to prevent HIV transmission between health care workers and their patients, and vice versa.

"We are recommending that notification is not necessarily the only way to protect the public," Dr. Ramirez said. "It is not the main thrust. Nor are we recommending mandatory HIV testing for health care workers. Every physician will be his or her own policeman."

"If we're going to prevent transmission by using universal precautions, we must assume that everyone is a source of infection," he continued. "Any patient potentially has AIDS, so everyone must be protected. If you're going to handle secretions, you have to wear gloves."

In the event that significant risk of HIV transmission from a health care worker exists, the task force has developed guidelines to establish expert panels to assess risk factors of HIV-positive health care workers. Such screening would be entirely voluntary and confidential. Panels would include a health professional with knowledge of procedures performed by the HIV-infected health care worker; an infectious disease specialist with expertise in HIV; an infection control physician versed in universal precautions and U.S. Occupational Safety and Health Administration requirements on exposure to bloodborne pathogens; an Illinois Department of Public Health representative; a medical ethics and law specialist; the personal primary health care provider of the infected health care worker; and a representative from a non-involved, non-competitive health care facility. He or she would, however, be required to follow the directions of the panel in such areas as practice restrictions.

*"If you look at the statistics, far more health care workers have been infected by patients than patients by their health care professionals."*

The task force emphasized the necessity of providing education for both the public and health care professionals, Dr. Ramirez said. "If you look at the statistics, far more health care workers have been infected by patients than patients by their health care professionals. In the state of Illinois, not one single case of HIV transmission from a physician to patients has occurred."

After extensive debate, the group also decided that health care providers should be notified if an HIV-infected patient indicates that an invasive procedure may have been performed.

"I think on the whole, the group is confident about our recommendations," he said. Dr. Ramirez expects that the task force will make few changes to the main body of the document they have constructed thus far. "The recommendations are based on scientific knowledge that cost considerations cannot affect," he said. ▲

# New trustee focuses on member recruitment

by Kevin O'Brien

ONE OF THE Illinois State Medical Society's newest trustees not only believes in membership recruitment, he actively practices it.

"Organized medicine cannot stand on its own without members - it's the root of everything we do. How else can I say it?" says Albino T. Bismonte Jr., M.D., a Gurnee pediatrician.

The ISMS House of Delegates April 12 elected Dr. Bismonte to a three-year term as a First District trustee. He takes the seat vacated by David B. Littman, M.D., Highland Park, who was elected secretary-treasurer.

Dr. Bismonte's track record at attracting new members has been consistently recognized by the American Medical Association which, he says, has presented him with its outreach program award "every year since becoming an alternate delegate in 1984 or 1985." Dr. Bismonte is a past



Albino T. Bismonte Jr., M.D.

president of the Lake County Medical Society and serves as a delegate to the AMA.

Asked his secret, Dr. Bismonte replies, "Practice, practice, practice." He

says being chair of the Lake County Medical Society's membership committee makes it easy for him to know who is and who is not a member. "So, if I know a doctor is not a member, I try to make contact. I try to carry a membership application with me all the time," says Dr. Bismonte. "But if I don't have one when I'm talking to someone, I just call the office and ask them to mail one out with a cover letter reminding the doctor of our conversation." ▲



# Universal health bills 'irresponsible,' lawmakers charge

by Tamara Strom

AFTER BEING VOTED out of committee with their multi-billion-dollar price tags removed, the two universal health insurance bills wending their way through the Illinois General Assembly are even more irresponsible, many legislators say.

"It's totally irresponsible not to address the issue of how you are going to fund this massive, unilateral health care system for Illinois," said Sen. Judy Baar Topinka (R-Berwyn). "I'm appalled to see this bill passed out of committee in light of the sheer amount of negative testimony generated during the hearings on the bills. When so many negatives were found about this system for one state and one state only it is outrageous for this bill to go forward."

Topinka singled out as particularly informative the testimony of Illinois State Medical Society President Arvind K. Goyal, M.D., during an April 22 joint House-Senate hearing on H.B. 2774 and S.B. 1495. "Dr. Goyal's testimony provided us with even more information than we already had," she said. "The facts he presented provided more support for those of us who already are against [the legislation]. It helped to solidify the opposition."

As the bills move closer to floor debate, however, Democratic lawmakers are signing on as co-sponsors in increasing numbers. In the House alone, 43 new co-sponsors have joined Rep. Anthony L. Young (D-Chicago) as the original bill sponsor. Sixty votes are necessary for passage in the House of Representatives.

The original bill's funding mechanism was based on proponents' assertions that the system would cost \$54 billion. According to ISMS figures, a tripling of personal income taxes and a new 11 percent employer payroll tax would be needed to meet the \$54 billion price tag in 1995, when the system would go into effect.

Topinka called the House and Senate health care committee votes "silly and simplistic," motivated by election-year politics. "We're just going through a drill to make some people and some legislators feel good," Topinka said of the votes sending the bills to their respective chambers. "Nothing serious or good could come of this. The state is so down and out now [financially] it can't take anymore." She said she is uncomfortable with the way universal health insurance supporters are "just throwing around numbers," estimating the cost of the system in the billions of dollars. "I have to question where the funding for this program would come from," she said.

Other lawmakers are asking those same questions. Rep. Jerry Weller (R-Morris), the minority spokesman on the House Health Care Committee, said the proposed universal health insurance program is "basically a \$30 billion tax increase and a \$54 billion spending program" that nearly triples the state's current budget. Without funding mechanisms attached, the bills become a political vehicle, a fact Weller laments. "It's

unfortunate in this political year that this universal health care program has been designated a political issue," he said.

Other questions also surround the amendments removing the program's proposed funding mechanism and calling for the establishment of a blue ribbon panel to suggest one. According to the amendment, submitted by Rep. Young after the hearings on the bills, the proposed system would be administered by eight elected regional boards that would set health care budgets subject to approval by the General Assembly. As such, they would seem to

have been delegated authority for setting appropriations, normally a function of the General Assembly.

Young did not respond to requests for comment from *Illinois Medicine*.

## Reforms could happen now

Weller said the universal health insurance program is "clearly divergent" from our current system, which he said is "frankly, the best in the world" with "quick diagnosis, quick treatment and the best technology available."

"There are many things we can do now to make our health care system more accessible and affordable," he

said, citing medical malpractice reforms, tax incentives for employers who provide health insurance to workers, establishing risk pools for health insurance coverage and standardizing claim forms to reduce administrative burdens.

Achieving meaningful health care reform will take a bipartisan effort, Weller said. "I recognize that this universal health issue will take leadership and reforms at the national level," he said. "But we at the state level need to work in a bipartisan manner to complement the initiatives of the president and others at the national level." ▲



  
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Universal health bills

(continued from page 1)

insurance industry practices. H.B. 2774 and S.B. 1495, however, meet virtually none of the criteria Illinois physicians established for achieving meaningful reform.

Instead, the bills call for a state-administered health care system that would provide unlimited care to all citizens regardless of their ability to pay. This system is bound to send health care costs soaring even higher, Dr. Goyal explained, because there are no incentives for patients to seek cost-effective, quality care. Without appropriate copayments and deductibles, patients will never fully understand the cost of the services they receive.

Based on the experiences of Canada, the single-payer system is also doomed to ration care, Dr. Goyal said. "These plans promise universal access to care," he said. "What they will deliver is universal rationing of care. Funding inadequacies end up denying access to the very patients who need medical care the most. This is not consistent with our objectives for health care reform."

Dr. Goyal noted that the ISMS principles call for development of a national package of basic health services to which all people would have equal access. In addition, the Society stresses the need for patients to take an active role in their own health by making healthy lifestyle choices, such as avoiding drugs, alcohol and tobacco; eating right and exercising; and avoiding preventable sexually transmissible diseases.

Other ISMS principles to which the single-payer system does not subscribe are reform of the health insurance industry and malpractice tort system. Dr. Goyal noted that although Illinois' physicians favor reform of the health insurance industry, the single-payer, government-administered system abolishes all health insurance except that provided by the state. This means 7 million Illinoisans now covered by private insurers would lose their coverage and be absorbed into the state's system.

"We should not take coverage away from people," Dr. Goyal said. "Instead, we should make sure private insurers live up to their end of the bargain." Among the insurance industry reforms physicians support are eliminating risk rating in favor of community rating and banning discrimination against patients with pre-existing conditions.

The universal health care system also makes no provisions to enact tort reform to ease the growing trend of skyrocketing malpractice judgments, the ISMS president said. The medical society has long held that capping non-economic judgments, the so-called pain and suffering awards, could save untold health care dollars by reducing defensive medicine and high malpractice premiums, costs subsequently passed on in higher charges.

"In order to solve Illinois' health care problems, we must look at a variety of issues," Dr. Goyal said. If we do not, and simply adopt this single-payer system, Illinois will not only have more health care problems, but serious economic problems as well." ▲

Rally

(continued from page 1)

letter. However, an April 28 letter from ISMS President Arvind K. Goyal, M.D., to Champaign-based Campaign for Better Health Care, which sponsored the demonstration, said a "mutually convenient meeting between a representative of your organization and ISMS may indeed be appropriate and beneficial at some future date."

Dr. Goyal told *Illinois Medicine* that ISMS does not use political action committee funds to "defeat meaningful health care reform," as demonstrators claimed. "It's the difference in the way you define 'meaningful' health care reform," he said. "We define meaningful health care reform as efforts to improve the health and well-being of our patients. We want to provide quality care to our patients, not ration care among our patients, a situation a single-payer, government-run system would certainly force. We do not support those plans that carry promises that cannot be kept."

Workers waiting four to six months

Steve Cullen, of AFSCME, the union that represents state workers, said many employees can no longer keep up with rising health insurance premiums and in many cases cannot afford health insurance for their dependents. In addition, Illinois' fiscal crisis is forcing the state employee health insurance program to delay reimbursement payments to workers for four to six months. "[This backlog] is straining their relationships

with their health care providers," Cullen said, adding that some physicians are now "demanding cash up front" to treat state workers. "We must tell the state legislature that we want no more Band-Aids; we want health care now."

Other speakers singled out ISMS' long-held support for reforming the malpractice tort system in Illinois. "I can understand the doctors' point of view; no one wants to be sued," said Bob Hudek, director of the Coalition for Consumer Rights. "The medical society's No. 1 obsession is to limit the ability of people to bring lawsuits against doctors and to put caps on the amount of money juries can award. It's wrong, it's immoral and it won't solve the problem."

Hudek said most physicians in Illinois are "doing a fine job." More than 70 percent of the doctors in Cook County, for example, have never been sued, he said.

The Illinois Nurses Association also rallied in favor of universal health insurance. Health care reform would enable patients to regain the freedom to choose their health care providers, including midwives and nurse practitioners, said Maureen Shekleton, INA immediate past president. "Women should be able to choose to go to a midwife and we all should [be able to go to] nurse practitioners for primary care," Shekleton said. "Organized medicine has made this [fight for universal health care] into a reimbursement issue. It's not; it's an access to care issue." ▲

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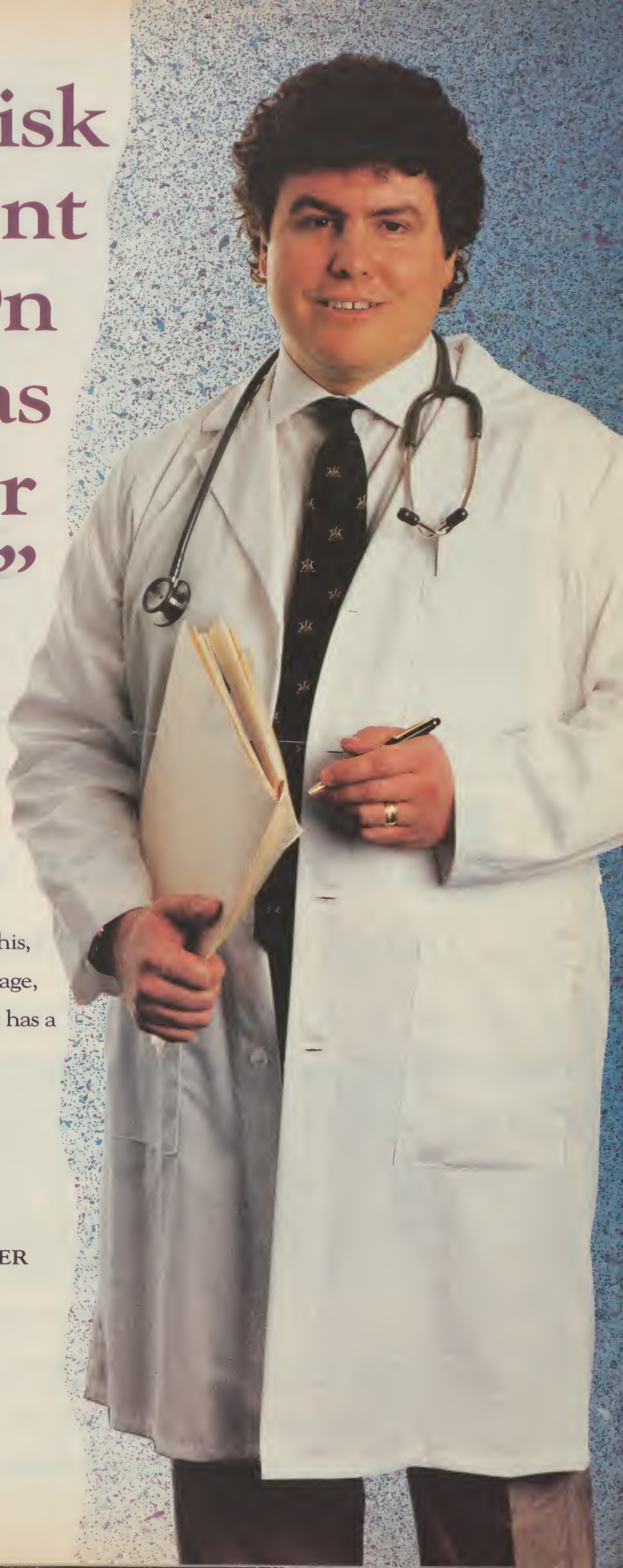
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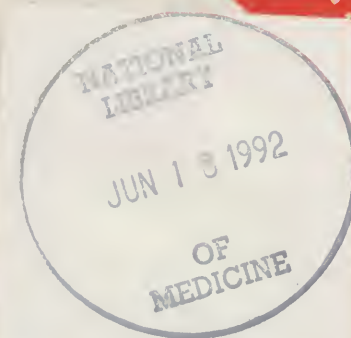




# Illinois Medicine

June 5, 1992

ILLINOIS STATE MEDICAL SOCIETY



The Auxiliary  
is changing: Guest  
Editorial..... 5

## Universal health bill stalls in House

by Tamara Strom

AS A RESULT of fierce pressure from the medical, business and insurance lobbies and a hostile amendment proposed by opponents of the measure, a bill creating a single-payer, state-run health care system stalled in the Illinois House of Representatives May 22. A last-gasp effort by the bill's sponsor Rep. Anthony L. Young (D-Chicago) to amend the bill, making it more palatable to the insurance industry, failed.

Instead, the bill has been amended with new language introduced by Rep. Jerry Weller (R-Morris) and 39 other Republican lawmakers that guts the single-payer proposal and calls instead for establishment of a "Bipartisan Health Care Reform Commission."

Weller's amendment was put forward because, "Health care reform is too important to the people who need it for the issue to become a political football," said House Minority Leader

Lee A. Daniels (R-Elmhurst) in his legislative update, *The Week in Review*. "Because a [single-payer, state-run] system that fattens the bureaucracy and leads to massive tax increases will not be signed into law, House Republicans have stepped forward with their proposal to break the deadlock," Daniels said.

The 17-member health care reform commission would study and identify solutions to Illinois' crisis in health care costs, and report its findings to the governor and the General Assembly before May 1, 1993. Com-

(continued on page 10)



Gregg Daniels

**Just say no to universal health care** Representatives of the health insurance industry rally in Springfield in opposition to H.B. 2774 and S.B. 1495, measures that propose a single-payer, state-run health care system for Illinois. The May 13 rally highlighted opponents' contentions that sick people from around the country would move to Illinois to receive the "free" unlimited care the system would offer.

## Auxilians lobby against universal health

by Tamara Strom

FORTY-FIVE Illinois State Medical Society Auxiliary members met at the state Capitol May 20 to learn more about the legislative process and hear updates on universal health bills in the General Assembly. Armed with their reinforced knowledge, the Auxilians headed to the Capitol to lobby lawmakers against H.B. 2774 and S.B. 1495, the two bills calling for a single-payer, government-run health care system in Illinois.

"Everyone here today learned a lot about the political process in Springfield," said Pam Taylor, Auxiliary legislative chairman. "They were all enthused about going over to the Capitol. And the Capitol certainly is a



Ron Ackerman

ISMS Auxilians lobby their legislators May 20 at the state Capitol to vote no on two universal health care measures.

madhouse right now."

Lawmakers in both houses were acting on budget considerations all day, Taylor said. The Auxilians watched the budget proceedings and then, like seasoned lobby-

ists, talked to their legislators about universal health care around the rail on the third floor of the Capitol rotunda. "Some [Auxilians] were very upset because their legislators said they were going to vote for the bills - even though they personally are opposed to it - because they think it's what their constituents want."

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## AIDS task force: Do not fund S.B. 999

by Anna Brown

GOV. JIM EDGAR'S Task Force on AIDS in Health Care voted at its final meeting May 11 to recommend that the state's HIV-AIDS notification law not be funded for implementation. The panel cited the lack of scientific basis for "look-back" studies and the need to direct financial resources to other AIDS preventive activities.

"Our recommendation is based on the idea that there may be better ways of spending money for AIDS than notification," said Nestor Ramirez, M.D., task force chairman. The task force hopes that this recommendation will spur continuous analysis of the new issues and problems that arise in the treatment of AIDS, he

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### Call your legislators!

ALTHOUGH universal health legislation in the General Assembly is stalled for now, physicians are urged to continue calling and writing their legislators to express their opposition to the proposal. During last year's legislative session similar universal health legislation was introduced and voted on late in the session as an amendment to another bill.

**Act now.** Keep your opposition to a single-payer, state-run health care system on your legislators' front burner. ▲

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## VA suspends surgery at North Chicago; doesn't discipline physicians

The U.S. Department of Veterans Affairs last month ordered the VA Medical Center-North Chicago to suspend all surgery that requires general anesthesia. The decision comes after more than a year of investigation of eight patient deaths at the hospital. The VA accepted responsibility for those deaths, saying the quality of care the patients received contributed to their deaths.

But while the VA came down on the hospital by suspending all surgery except outpatient and non-general anesthesia procedures and calling for a more limited affiliation with the Chicago Medical School, the agency did not discipline the VA physicians who treated the patients in question. "The regulations we operate under have carefully and thoroughly defined procedures to protect the right of all government employees and particularly those in the health care area," said David West, chief of media relations for the Veterans Health Services and Research Administration. "Multiple reviews and inspections of the hospital were conducted by the Veterans Health Administration, the Inspector General and others outside of VHA. By the time we got through all of these reviews, it was not possible to always guarantee those rights. The overlapping reviews made it difficult to determine who did what when. Therefore, from a strictly legal standpoint, we decided not to go ahead with disciplinary action because it could be successfully challenged and overturned."

Those physicians still employed by the VA will undergo counseling, West said, adding that because the agency decided against disciplinary action "doesn't mean they escaped accountability." He stressed this counseling is not considered disciplinary action by the VA. For some physicians, such as residents or doctors who have changed jobs in the past year, the medical director at North Chicago will review the pa-

tient files and determine if any of them should be reported to the National Practitioner Data Bank or the state licensing board. "The due process rights of these doctors would be upheld" if the VA decides to report these doctors, West said. "They have ample due process protections."

## Fear of lawsuits boosts defensive medicine

The fear of being sued for medical malpractice forces physicians to order additional and sometimes unnecessary diagnostic tests, according to new results from a Gallup survey for the American Medical Association. Eighty-four percent of the U.S. physicians surveyed said they practice such defensive medicine procedures, up from 75 percent in 1989 and 78 percent in 1986, the survey revealed.

"This figure is the highest in survey history and demonstrates the increasingly detrimental effect the fear of malpractice has on the cost of health care in this country," said James S. Todd, M.D., AMA executive vice president. "The cost is \$20 billion annually and rising."

## HCFA gives MDs another 1500 form reprieve

Just as you were getting ready to throw out your unused Medicare Part B claim forms, the U.S. Health Care Financing Administration is giving you another chance to exhaust any leftovers you might have. While HCFA had given physicians a May 1 deadline to use only the new Medicare 1500 standard claim forms, the agency has again extended the deadline to July 1.

Illinois State Medical Society advisers recommend physicians use the old claim forms only to exhaust remaining supplies. Physicians who have already made the switch to the 1500 form can simply continue submitting claims as they have. The new 1500 forms are the only Medicare claim forms now available from the AMA and the Government Printing Office. ▲

— by Tamara Strom

# Governor announces new hospital assessment plan

by Tamara Strom

TRYING TO SALVAGE more than \$700 million in federal matching funds for Medicaid, Gov. Jim Edgar May 27 unveiled a refurbished health care facility assessment plan, establishing broad-based provider taxes. Without legislative action enacting the new plan, the state's current institutional assessment program becomes illegal Sept. 30 because it does not comply with federal legislation adopted last fall. Neither the current law nor the new plan assesses physicians.

"On the line is \$735 million in federal funding to help support hospitals, nursing homes and other facilities that serve the needy," Edgar said in announcing his plan in Chicago and Springfield. "If the General Assembly does not act before Oct. 1 to preserve that funding, many health care institutions will be forced to close their doors. It is clear the future of hospitals that serve the needy in metropolitan and rural areas of our state are on the line, and we must respond fairly, forcefully and

realistically."

Under the plan, hospitals would be assessed 2.9 percent of their net patient revenues. Nursing homes would be assessed \$6.30 a day per occupied bed; facilities for the developmentally disabled would be assessed 13 percent of their residential revenues. Made in quarterly installments, these payments would then be matched by the federal government, bringing needed dollars into Illinois for its underfunded Medicaid program, Edgar said. The program will benefit more than 80 percent of health care facilities, the governor said.

"Most of the facilities that do not benefit are doing very well financially and should be able to pay their assessments without raising rates on their patients," Edgar said. "The only realistic alternatives to this program are to slash payments to providers by at least 30 percent, thereby putting many of them out of business, or to raise income taxes to generate the matching funds. I reject both of those alternatives."

(continued on page 13)

## Senior health fairs improve senior citizen-physician relationships

by Rachel Brown

BUILDING ON THE Illinois State Medical Society's award-winning "Partners for Health" program, the ISMS Auxiliary organized senior health fairs in St. Clair and Winnebago counties to encourage communication between seniors and area physicians.

The St. Clair County Medical Society Auxiliary health fair March 18 was held in conjunction with Belleville Area College and a Belleville senior citizens center.

More than 50 seniors attended the fair, which featured roundtable discussions with eight area physicians. The informal setup allowed seniors to move from table to table and ask questions on topics ranging from Alzheimer's disease to living wills, said Marge Scovitzch, R.N., who assisted in coordinating the fair.

"The seniors went out singing [the health fair's] praises," Scovitzch said. "[We] succeeded in bringing physicians off a pedestal in the eyes of the seniors and showed that they are human and can be of service."

Debbie Haake, St. Clair County Auxiliary president, agreed. "The atmosphere was relaxed and very friendly, and the seniors were very impressed that the physicians left their offices to share time with them," she said.

The second health fair, held March 30 to observe Doctor's Day,

was sponsored by the Winnebago County Medical Society Auxiliary. The half-day event at the University of Illinois College of Medicine at Rockford included presentations by Rockford family physician Robert E. Heerens, M.D.; Nancy Nelson, acting director of the Illinois Department on Aging; and a local nurse. They discussed trends in medicine and senior health care, state-sponsored health programs and advance directives, said Kim Edgcomb, Auxiliary co-chair of the fair.

Each county was responsible for organizing the fairs, with ISMS supplying promotional posters and sample press materials. ISMS also supplied copies of the advance directives brochure, "A Personal Decision," and "Healthy Partnership Kits" with Medicare information, tips on patient-physician communication and lists of area agencies on aging.

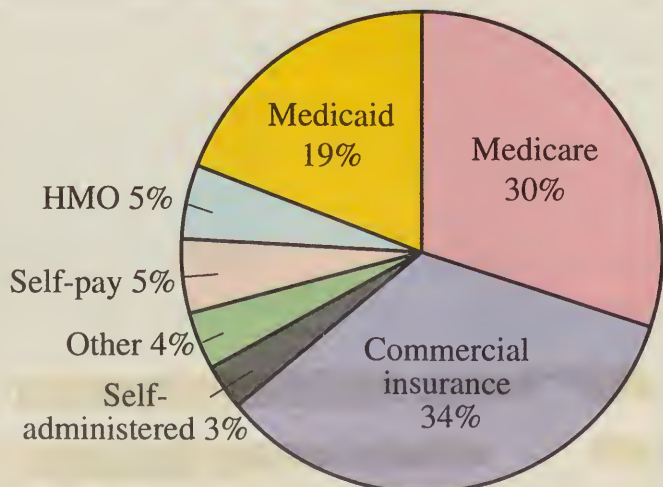
The Winnebago and St. Clair county health fairs are the result of the Auxiliary's efforts to expand the "Partners for Health" program. The half- and full-day senior health fairs benefit both seniors and physicians, improving relationships and encouraging communication.

"This program is our way of saying to the seniors, 'We really care about preventive medicine, we care about taking care of you and we want to have our lines of communication open,'" said Nancy Hoffmann, ISMS Auxiliary program chairman. ▲

## Physician Facts

### Health insurance coverage of Illinois inpatients in 1991

Nearly half of all patients treated at Illinois hospitals on an inpatient basis in 1991 were enrolled in the government-funded health insurance programs Medicare or Medicaid.



Source: Illinois Health Care Cost Containment Council, *Health Cost Update*, spring 1992.

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by Tamara Strom

AS THE MAY 22 deadline for bills in the General Assembly to pass out of their house of origin came and went, political maneuvering by concerned parties and lawmakers kept several health care-related bills alive for this legislative session. Other bills — such as H.B. 2774 and S.B. 1495, both of which propose a single-payer, state-run health care system for Illinois — weren't so lucky.

The Illinois State Medical Society lobbied successfully against universal health care measures and helped craft language for changing the law regarding physician participation in state-ordered executions.

The Society watched carefully the progress of the following bills during the past weeks:

**Universal health care ...** One of ISMS' top priorities this legislative session, medical society officials lobbied long and hard to see these bills go down to defeat. Last-minute amendments by supporters and opponents effectively stalled the legislation for the time being, although they could still resurface before the session ends June 30.

**Statewide referendum ...** H.B. 3806, sponsored by Rep. Jan Schakowsky (D-Evanston), and S.B. 2117, sponsored by Sen. Vincent Demuzio (D-Carlinville), which called for a November statewide referendum on universal health care, never made it out of committee. The bills were supported by Illinois State Treasurer Patrick Quinn. These bills also are still viable through any number of procedural tactics.

**Physician participation in state-ordered executions ...** This ISMS-backed legislation would bring current law into line with House of Delegates policy adopted last year. H.B. 3607, sponsored by Rep. Thomas J. Homer (D-Canton), enjoyed clear sailing through the Illinois House and advanced to the Senate May 20. The bill removes the current statutory requirement that two of eight witnesses at an execution be physicians, reducing the number of required witnesses to six. The bill also would delete the requirement that a physician pronounce death, shifting this responsibility to the coroner. It is uncertain whether new ISMS policy adopted at the 1992 annual meeting calling for identification of physician witnesses or participants in executions by the Illinois Department of Corrections can be enacted this year. ISMS will continue to try to amend the bill in the Senate.

**Self-referral legislation ...** Legislation in the House and Senate to regulate physician referral practices is one of the session's hottest health care topics. An array of lobbyists representing interested parties worked the rail for and against S.B. 2201, sponsored by Sen. William A. Marovitz (D-Chicago), and H.B. 4044, sponsored by Rep. John S. Matijevich (D-Waukegan). The impetus for General Assembly action on this issue stemmed from members of the Illinois Radiological Society. After fierce lobbying and negotiations on both sides of the issue, both bills failed to clear their house

of origin, stalling the measures for now. But this issue is still active in Springfield, and legislative action on self-referral appears highly likely before the General Assembly adjourns.

The ISMS Executive Committee in May endorsed self-referral restrictions as outlined in a report on self-referral released by the American Medical Association's Council on Ethical and Judicial Affairs. According to the guidelines, "Physicians may refer their patients to facilities in which they have an ownership interest if the physician directly provides care or services at

the facility." The guidelines also allow referrals for physicians who own health care facilities to which they refer patients where a demonstrated need exists or where other sources of capital to establish the facility cannot be found.

Using the provisions of the AMA report as a benchmark, ISMS voiced concerns that any legislation must not bar physicians from referring patients for services within their own practice. Society efforts have largely centered on creating amendatory language to submit to bill sponsors that broadly addresses the self-referral issue. ISMS drafts would give the Illinois Health Facilities Planning Board the future flexibility to more specifically define what constitutes acceptable referrals when physicians hold an investment interest.

While ISMS did not initiate this legislation, bill sponsors and other supporters are actively soliciting the Society's opinion on various drafts of amendments to it. However, because of the large number of interested parties there is no guarantee that bill sponsors or the General Assembly will accept all ISMS recommendations. As bill sponsors continue looking for vehicle bills to advance their self-referral measures, ISMS is working with lawmakers to craft amendments consistent with the AMA guidelines restricting self-referral.

**Mandatory assignment for Medicare ...** Killed in committee was H.B. 3806, aimed at prohibiting physicians from charging or collecting for Medicare Part B services in excess of U.S. Department of Health and Hu-

(continued on page 12)



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## REPORT

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Under PSCS, Medicare B claims will be displayed for up to fifteen days in the "Submitted" status and fifteen additional days in the "Finalized" status. Blue Cross and Blue Shield claims will be available for 45 days from the received date.

#### Questions and Answers

Below is a sample of frequently-asked questions from the BCBSI Provider Assistance Unit:

##### Where should claims be mailed ?

Blue Shield of Illinois  
PO Box 1364  
Chicago, IL 60690

##### What is my patient's deductible, effective date, and waiting period ?

For the quickest possible service, contact the Provider Assistance Unit at (312) 938-7340 and simply enter patient information as requested. If special assistance is required for your request, one of our representatives will be happy to assist you Monday through Friday between 8:30 am and 4:15 pm.

##### When should reimbursement for my services be received ?

Generally, you should expect to receive reimbursement within 10 days of the date of your Provider Claims Summary (PCS) document. If you have not received reimbursement within this timeframe, please contact the Provider Assistance Unit at (312) 938-7340 for further information.

(This report is published as a service to the physicians of Illinois.)  
(6/5/92)



## Editorial

## Keep it up

**T**he pressure, that is. If you haven't called your state senator or the House member from your district to express your concern over the universal health proposals being considered in Springfield, do it today. If you already have done so, think about doing it again after you read this. Because both bills are very much alive. Although neither passed out of their house of origin by the specified deadline, either can be amended onto another bill; that's what happened last year. It could happen again this year.

The events of the past two weeks underscore the idea that health care is far too important to be left to politicians alone. The House bill's sponsor, Anthony Young, introduced a last-minute amendment to his own bill that allegedly offered two kinds of universal health: multiple payer and single payer. (If you were of the cynical bent, you might interpret the multiple-payer option as an effort to neutralize the insurance industry's opposition to universal health.)

While that amendment didn't pass, it demonstrates once again that our patients' health cannot be a political football. The best thing you can say about a football is that it gets kicked around a lot before it's discarded.

The funding mechanism has been amended out of the bill. In an election year like this one, it's a lot easier to vote for a proposal like universal health if there's no hefty tax increase attached. After the elections there's plenty of time to figure out the price tag. This is irresponsible grandstanding. Let your legislators (and patients) know the truth and consequences of this "universal" health disaster; now and in the November election.

## What if?

**W**hat if universal health fails in Springfield? What if the bills don't move and the proposal dies? What if Oregon gets its federal waivers and begins to deny care based on its priority list? What if Iowa adopts its "pay or play" plan? What if the Minnesota plan proceeds? What if universal health turns up as a referendum on the November ballot?

The point here is that the issue of health care is not going to go away, no matter what happens to S.B. 1495 and H.B. 2774. On both the state and federal levels, reform of America's health care delivery and financing systems is going to be the hottest topic in campaign rhetoric. It is ludicrous to think that any successful or positive change in health care can be accomplished without the input and support of physicians.

Making our voices heard in this debate must be our top priority. In Springfield we must build on the excellence of our lobbying staff's performance by reaching out individually to the state senators and representatives who will be voting on these issues. Our contributions to IMPAC will help at both the state and federal levels. And finally, our "hometown" outreach efforts, to our patients, our neighbors and our community leadership, can help educate an electorate that will face important questions in November. It's a lot of work – and it's all necessary if we are to keep health care going in the direction best for our patients. ▲

## Illinois Medicine

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## President's Column

Story of recovery center bills

## Well done is better than well said

by Arvind K. Goyal, M.D.

Passing through a small town, an army officer was amazed when he saw numerous bull's-eyes on trees, walls, fences and barns with bullet holes in the exact center. He asked to meet the remarkable marksman.

"This is the most talented marksmanship I have ever seen," said the army officer, "How in the world do you do it?"

"Easy as pie. I shoot first and draw the circle afterwards."

Such options do not exist for most things in life. Success usually involves some risk. To hit a bull's-eye in Springfield, you have to miss some other things. Postsurgical recovery center bills are no exception.

The debate in the ISMS House of Delegates last year and again this year was lengthy but pointed. Both sides of the issue were heard until the cows went home. ISMS support for establishment of pilot postsurgical recovery centers for a short overnight stay as an alternative to expensive and inconvenient hospitalization while preserving quality and safety of patient care was called for by an overwhelming majority of delegates representing you. But that effort in Springfield failed last year. The legislature instead directed appointment of an Acute Care Task Force to analyze and report back on the issue.

As your president-elect at the time, I was surprised and honored to be appointed by the director of the Illinois Department of Public Health to represent you on this 19-member Task Force representing diversity of experience and interest. I was neither a proponent nor an opponent of recovery centers. And I did not possess any special expertise. My only credential being participation at the tail end of that debate in our House of Delegates.

The first two Task Force meetings occurred in Chicago, the other two in Springfield. I sat through all four of those half-day meetings, hearing testimony and argument from many experts and special interest groups – some of which I did not know existed! Representatives of successful recovery centers in other states also testified. I was impressed. Some hospital representatives invoked the potential of imbalance in health care delivery if such recovery centers came into being. Testimony was presented against this new market competition for hospitals, which they said, were already hurting.

The Task Force recommended careful evaluation of these new entities before and during their pilot period of no more than five years. Application for participation in Medicare and Medicaid programs was required. Charitable care equal to other providers in the area was expected. Certificate of need and other quality assurance requirements were put in place. The proposal was approved by the Task Force members with scanty opposition and few abstentions.

Then a freestanding birthing center model was proposed. On your behalf



Arvind K. Goyal, M.D.

and based on recognized obstetrical guidelines, I made a case for approval of those birthing centers attached to an existing hospital facility. The arguments on behalf of geographically isolated areas of state were very convincing – those areas where OB care is not available for 100 or more miles. A case was made for birthing centers contracted with a qualified hospital no more than 15 minutes away. Other checks and balances were also created. Participation in Illinois Perinatal System Network was required. Physicians on staff at birthing centers must maintain privileges at the contracting hospital. Again, review mechanisms by Illinois Health Facilities Planning Board, Illinois Department of Public Health, and the new State Board of Health were also put in place. In accordance with our House policy, I voted on your behalf with the American College of Obstetricians and Gynecologists representative on the Task Force.

I now understand, a total of three such bills were introduced in the legislature this session. One of these three bills was introduced on behalf of the Task Force, the other two independently with some differences. Your Society fully intends to support only legislation that is in full conformity with our House policy and protects the quality of care our patients deserve and demand.

Some of you are obviously concerned since our legislative process can sometimes deliver surprises. I am more concerned with division amongst ourselves and innuendos of "conflict" on both sides of the issue. The rumor has it that some local opposition may be employed by a hospital and speak less for our profession and our patients. On the other side there are suggestions that some supporters may have entrepreneurial interest individually or on behalf of the hospitals they are associated with.

Diversity in an organization can be positive. Dissent may be healthy to a certain point. But then, we must concede to a majority wish of our own House of Delegates. Those who did not prevail in our own House, now persist in countering our own lobbyists in Springfield. That effort can hurt us even on other more important matters. The lawmakers can receive potentially confusing and inconsistent signals. The House policy as determined, must be binding, even on those minority members who disagree with that policy. Their right to free speech should not interfere with actions on behalf of your Society. Those of us who disagree must work from within and our dedicated lobbyists must be allowed to do the job they are paid to do.

They can, if we let them. ▲

ARVIND

Arvind K. Goyal, M.D.  
President



## Guest Editorial

The world –  
and the  
Auxiliary – is  
changing

by Carol Gapsis

The world is changing. What was once the Soviet Union has disintegrated. The governments of East Germany and West Germany have become one. And here in our own country, medicine seems to be on the brink of becoming socialized, with its future uncertain. Solo practices are becoming a thing of the past, while group practices and clinics are the wave of the future.

Indeed, today's medical saga is like the opening lines of Charles Dickens' epic novel *A Tale of Two Cities* – "It was the best of times, it was the worst of times." The best of technology and scientific knowledge are pitted against moral and ethical issues never faced before. Organ transplants give new hope to the ill and dying, as society struggles with deciding who should receive them and who should pay the cost. Immunizations have all but conquered many killer diseases. Yet AIDS lurks as an awful unconquered disease and others, such as tuberculosis, are making a comeback. Life expectancy continues to rise, while our youth face an unparalleled mortality and morbidity rate. Innovative technology gives new hope to the terminally ill, but society grapples with deciding how long to prolong life when there is no hope.

The Illinois State Medical Society Auxiliary is also changing. We are no longer the stay-at-home women of the 1950s and 1960s. Although some of our members are still the backbone of volunteer efforts in our communities, we have dwindling numbers of full-time homemakers in our ranks. Today, we are psychologists, teachers, nurses, musicians and artists. We are physicians, lawyers, business owners and community leaders. Many of us manage the medical offices of our spouses. For the first time, two years ago, a state medical auxiliary president in Indiana was a male spouse. This year, we are pleased to announce that a male spouse from Adams County will serve on the ISMS Auxiliary Membership Committee.

The new Auxiliary offers members an opportunity to play a vital role in our communities and in organized medicine. Donations to the Ameri-

can Medical Association Education and Research Foundation, which totaled more than \$2.4 million last year, go directly to medical schools across the nation to ensure quality medical education. Other potential health care providers receive funds through local Auxilian scholarship programs. Illinois Auxilians reach out to communities through health education programs that range from the use of infant car seats to teen health topics and senior citizens' programs. We are active in the legislative arena, and our highly touted mini-internship program has demonstrated its effectiveness in educating legislators, community and business leaders about what it is *really* like to be a doctor.

Our agenda of Auxiliary programs and projects is expanding – as we continue to make a difference in our communities throughout Illinois. In all that we do, Auxilians are positive ambassadors for medicine. We get things done. And we have a tremendous desire to keep getting things done – to move ahead, to serve more people, to become the best that we can possibly be, to help improve and change the world around us.

I am sure that in 1927 the founding members of the Auxiliary had no idea of the complexity of issues that medicine would face today. They could not have foreseen how crucial it would be for physicians and their spouses to function as a team in their efforts on behalf of quality health care. This is why it is

*"Auxilians are positive  
ambassadors for medicine.  
We get things done."*

so important that you encourage your spouse to join us. We know that we must "time-share" with other volunteer organizations (schools, churches, civic and cultural groups) that impact all our lives. But we also know that people in our communities – our patients – are more informed and better equipped to address the crucial health care issues facing our society because Auxiliary members have used their ability to make a real difference through education, communication, action and support. If every ISMS spouse was involved, donating just a small portion of his or her time to even one project, our influence would be unbeatable.

Change in our world happens because people want change to happen. And if we don't like it, if we sit and complain, then we are reacting to change instead of making change happen. By working in a partnership – physicians and spouses – as a unified team, the Auxiliary will continue to be a positive force to change and shape the health care of tomorrow and remain a vital, effective, active voice for medicine. ▲

*Carol Gapsis is president of the ISMS Auxiliary.*



*Illinois State Medical Society Auxilians gather outside the state Capitol in Springfield May 20. The Auxiliary sponsored an all-day seminar to educate its members and encourage their participation in the legislative process.*

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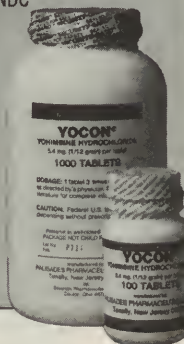
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

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# CASE in POINT

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin

## Case #1

**Presenting complaint and initial diagnosis** – Just before midnight, a mother brought her unconscious 7-month-old son to a hospital emergency room. The child had a 106-degree fever, appeared dehydrated and was having difficulty breathing. His mother said he had been convulsing. The ER physician examined the child and immediately administered oxygen and suction, and began slight cardiac stimulation. He preliminarily diagnosed febrile convulsion.

**The case in brief** – A lumbar tap was done to rule out meningitis and a blood test revealed an abnormally high white cell count. The ER physician tried, but was unable to start, an IV. One hour later, an on-call pediatrician in the hospital was called, but was delayed caring for a severely ill newborn. When he arrived, he attempted a cutdown to start an IV, but was unsuccessful. The boy convulsed twice during the night; paraldehyde was given by enema and oxygen again administered. Following a third convulsion, cold packs were applied to bring down the baby's fever. The boy's own pediatrician was called about 4 a.m. He arrived within the hour, but his efforts to do a cutdown to start an IV also failed. Six hours after arriving in the ER, the child was transferred by ambulance to a high-risk center. He suffered cardiac arrest en route, and although medical personnel revived him, the boy suffered permanent brain damage.

**The resulting claim** – The parents sued the treating physicians, alleging failure to intubate and failure to immediately consult a specialist (surgeon) who could do a cutdown and start an IV.

**The outcome of the claim** – The case was settled for more than \$1.4 million.

## Case #2

**Presenting complaint and initial diagnosis** – An otolaryngologist performed a polypectomy on a 58-year-old man to relieve chronic breathing problems.

**The case in brief** – Following surgery, the patient's left eye became extremely swollen. Vision was normal in both eyes immediately following the procedure, but two days later, the patient complained of increasingly blurred vision in his left

eye. The physician ordered a CT scan, which revealed a small abscess in the left orbit. The abscess was drained and antibiotics administered. A subsequent CT scan showed the abscess was absorbing, but the man's vision in his left eye never returned.

**The resulting claim** – The patient sued, alleging the otolaryngologist negligently performed the polypectomy, perforating the orbit of the left eye and permitting an infection to develop that led to blindness in the left eye. He also alleged the otolaryngologist failed to immediately consult with an ophthalmologist.

Experts reviewing the case generally agreed that a consultation should have been obtained within five to six hours after the swelling was noted, so the hematoma could have been immediately drained to prevent permanent damage to the eye. The defendant argued that blindness is a known complication of surgery in the ethmoid and that he had explained this to the patient. The physician's operative notes were sketchy, however, and his postoperative notes were confusing.

**The outcome of the claim** – The case was settled for \$185,000.

## Case #3

**Presenting complaint and initial diagnosis** – A 44-year-old man was admitted to an ICU following an acute drug overdose. Two days later, he was transferred to a medical unit.

**The case in brief** – During the next 24 hours, nurses told a general practitioner providing follow-up medical care that the patient had been exhibiting bizarre behavior. At one point, the man was discovered on the floor saying he heard bells ringing. Later, his roommate said the man had stolen razor blades and tried to hurt himself. On the second evening, the general practitioner again saw the patient after nurses reported more inappropriate behavior. The physician ordered a routine psychiatric consult from the in-house psychiatrist. Five hours later, hospital personnel discovered the man hanged from a curtain rod in his room, with a posey restraint tied

around his neck. He was resuscitated but never regained consciousness and died three months later.

**The resulting claim** – The patient's family sued the hospital, its employees and the treating physician for negligent care and wrongful death. Several problems made it impossible to defend this case. First, the physician admitted that if he had paid closer attention to the nurses' reports of apparent psychotic behavior, he would have ordered a stat psychiatric consult. Second, the physician failed to comply with hospital protocols in such cases. These included requiring that drug-intoxicated patients be sent to a medical floor, ordering a psychiatric consult as soon as possible and taking appropriate suicide precautions with the patient monitored every 30 minutes. Nurses did not observe the monitoring requirement and used a posey restraint neither ordered nor approved by a physician.

**The outcome of the claim** – The hospital and physician settled the case for more than \$800,000.

**The points these cases make** – Failure to call for a timely consult is a difficult allegation to counter in a liability action, especially when an adverse outcome occurred that arguably could have been prevented. Fred Z. White, M.D., a Peoria family physician and member of the Illinois State Medical Inter-Insurance Exchange Risk Management Committee, says the decision to request a consult is an important and often vital judgment call.

That judgment call begins when a physician recognizes his or her own professional limitations, which are determined by training and experience. Dr. White says that as a family physician, he frequently makes this decision. He suggests that all physicians, regardless of specialty, always ask themselves, "How sick is this patient? Is this something I can handle?" He also cites the following "red flags" that suggest a consultation is appropriate:

- A patient is extremely sick. "If a baby is convulsing, or an adult patient appears extremely ill, that's when I call for help fast," says Dr. White.

- A physician is not sure what is wrong with a patient.
- A patient is diagnosed, but does not respond to treatment as expected within a reasonable time.
- A patient's problem is beyond a physician's scope of practice.

"Know your limitations and don't exceed them," Dr. White advises all physicians. "Psychiatric problems, for example, are beyond the limits of a generalist."

That rule also holds for specialists. A surgeon may encounter a problem that requires a consult with another specialist. An otolaryngologist may seek help from an ophthalmologist, and vice versa.

Dr. White says that physicians sometimes hesitate to request a consult because they hate to admit they do not know something, and consequently sometimes go beyond their area of competence. Or, they may resist calling for a consult because they hate to bother a colleague in the middle of the night, or at another busy or inconvenient time. Dr. White warns physicians to ignore such feelings. "We must call a consultant whenever one is needed. That's what a consultant is for."

More important, Dr. White says, a physician may violate the standard of care if he or she fails to request a consult. "A physician is held to the standard of care for his or her particular field of medicine," he says. "So, if a physician doesn't call for a consult when seeing a patient whose problems may be beyond the physician's limits, he or she could be liable if a malpractice claim arises."

While most generalists can handle perhaps 98 percent of their patient's problems, Dr. White warns that "this does not include the extreme or exotic ones," for which a consultation is mandatory. He notes that knowing when to call for a consult may not always be clear-cut, but emphasizes that when a physician sees a patient exhibiting any of the red flags identified above, "That's the time to demand help." ▲

*Carol Brierly Golin is publisher of Medical Liability Monitor.*

## Stress seminar hits its mark

by Anna Brown

ILLINOIS PHYSICIANS are taking advantage of the Illinois State Medical Inter-Insurance Exchange risk management seminar "Taking Control: Managing Your Malpractice Lawsuit," designed to help doctors cope with the stress of the litigation process. Nearly 50 physicians and spouses participated in the May 6 presentation in Lincolnshire, and the Exchange expects its next two offerings, scheduled for the fall, to be just as popular.

"The seminars are going very well. We've had very good turnout," says James P. Ahstrom Jr., M.D., seminar moderator and chairman of the Exchange Physician Support Group.

"We try to familiarize physicians

with the litigation process so that they can 'take control' of the situation, as the title suggests," Dr. Ahstrom says. "We describe what happens from when they first receive notice of a claim through the defense process, the deposition and the trial."

Dr. Ahstrom explains that while many suits never come to trial, those that do can be very stressful. Physicians still are deposed and are involved in research and preparation before the decision is made to settle or defend the case. The goal is to educate the physician to be better prepared to cope with the rigorous emotional demands of the litigation process, he says.

The seminar, open to physicians and their spouses, is conducted by a

panel of experts, including Dr. Ahstrom, an Exchange defense attorney and an Exchange claims analyst. Panelists review the discovery process, the personal and professional effects of lawsuits, and the Exchange defense policy. The seminar offers physicians a confidential arena to air frustrations and concerns, and to ask questions they might otherwise keep private.

The next presentations of "Taking Control: Managing Your Malpractice Lawsuit" will be Sept. 9 at the Oak Brook Hyatt Hotel in DuPage County and Oct. 21 at the Holiday Inn-Collinsville in Madison County. For a brochure and registration information on this and other Exchange seminars, contact the Exchange risk management department at (312) 782-2749 or (800) 782-ISMS. ▲



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The Regional Organ Bank of Illinois in April started a campaign targeting large population bases. Posters like this one are appearing on buses and trains in Chicago, Rockford, Peoria, Springfield and Bloomington.

# New organ donation programs may decrease waiting lists

by Anna Brown

TWO NEW PROGRAMS – one initiated by the state, the other by the Regional Organ Bank of Illinois – hope to ease the organ donation crisis in Illinois. One creates a state organ donor registry and the other begins a program where organs from deceased trauma patients can be preserved and transplanted. Currently, organs are harvested only from brain-dead patients on respirators.

Illinois Secretary of State George H. Ryan announced April 22 the creation of a state organ registry of Illi-

nois driver's license applicants who wish to donate their organs.

"This registry will greatly improve the ability of organ procurement groups to identify potential donors," Ryan said. "None of us has the power to anticipate our death, but we do have the power, with only a moment or two of forethought, to give life to a fellow human being."

The information gathered for the new data base, which will start up in January 1993, will be available only to registered organ procurement groups such as ROBI, said Ryan's spokesman John Torre. About 2 mil-

lion people apply for or renew driver's licenses each year in Illinois. The registry will greatly enhance public awareness about organ donation, he said.

"We're not going to badger anyone," Torre continued. "This is a strictly voluntary program. We will be asking groups like ROBI to help train our employees to ask applicants if they would like to sign the backs of their licenses, and if so, they would ask them also to be part of the registry."

Since 1984, Illinoisans have had the option of using their driver's licenses to indicate their wish to donate their organs. The applicant may choose to donate a specific organ or the entire body, and two people must witness the signature.

The new registry will not be legally binding, and procurement groups will still seek family consent before organs are harvested, Torre said.

Illinois is the fourth state to create such a registry, after Florida, Maryland and Ohio. Torre said legislation to create the new program was not necessary since the format of the Illinois driver's license will not be changed.



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### Kidney patients stand to gain from new program

Complementing the state's new registry is ROBI's plan to recruit hospitals for a program that could double the number of kidneys currently available for transplant in Illinois, ROBI Director of Operations Lawrence Hopkins told *Illinois Medicine*. There are 900 people on the waiting list for kidneys in Illinois and the new program could eliminate the list altogether, he said.

Under the program, kidneys of trauma patients who die will be perfused with a preservative that will keep them in transplantable condition for several hours. This will secure enough time for health care workers to obtain from family members consent for removal. Previously, once the patient had died, the organs deteriorated too fast to obtain consent and, consequently, were not harvested. Hopkins said the preservative is administered through a small incision via the femoral artery, resulting in less mutilation than an autopsy or even some resuscitative procedures. Kidneys are not removed until family consent is given.

To date, only Loyola University Medical Center in Maywood has joined the program, but ROBI is initiating talks with several other hospitals throughout the state.

"This is a research effort in that we know from past experience under the old protocol that we had a high rate of non-functioning kidneys," said David Hatch, M.D., assistant professor of urology at Loyola University Stritch School of Medicine. He explained that the Loyola program is being conducted using a similar, but superior, preservative to solutions tested in Japan and Holland in the last decade.

Loyola has perfused and tested six kidneys since the program began. The goal, said Dr. Hatch, is to perfuse 10 kidneys to help decide who could best benefit from these transplants. Currently, no kidney transplants have been performed at Loyola using a non-heartbeat donor.

"We think this will be a program that works," Hopkins said. "At first,



# IDPH honors heroes during Emergency Medical Services Week

by Anna Brown

FROM A HIGH school student who administered the Heimlich maneuver to paramedics who discovered a dangerously high level of gas in a seizure victim's home, the Illinois Department of Public Health recently honored individuals from across the state with awards for acts of courage.

IDPH recognized as heroes 20 Chicago-area people and 12 from downstate as part of Emergency Medical Services Week activities in May. Gov. Jim Edgar endorsed EMS Week to commend the dedication to duty of Illinoisans involved in emergency medical services. In addition to the 32 awards, three individuals and two institutions were recognized for their contributions to emergency medical services.

---

*"It takes an exceptional person to choose a career in EMS, for these men and women know their lives and the lives of others may be on the line."*

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Both private citizens and emergency professionals were honored in ceremonies in Chicago and Springfield for their acts of extraordinary courage during the past two years. Feats of bravery cited during the ceremonies included teams of firefight-

ers and paramedics who rescued and resuscitated people trapped in burning buildings, aided assault victims and saved people trapped in their cars after accidents. Also honored was a seventh grader who rescued his younger brother from a fire and a nine-year-old who called 911 and, with the aid of a police officer and dispatcher, saved his wheelchair-bound grandmother from a fire.

"The persons honored today define heroism," said IDPH Director John R. Lumpkin, M.D., who presented the awards with Leslee Stein-Spencer, chief of the department's Division of Emergency Medical Services and Highway Safety. "They willingly risked their own lives to save

the life of another. In recognizing these civilians and professionals, we salute all emergency medical personnel throughout Illinois."

One particularly harrowing incident involved a man trapped in a deep hole between two one-ton sewer pipes. Two of the honored EMTs rescued the man with the aid of the fire department's ladder only 60 seconds before the hole collapsed.

A Southern Illinois University student was honored posthumously at the Chicago ceremony. Steve Martin Schaefer had attempted to warn tenants in his apartment building that it was on fire, and had gone in to see if anyone was left inside. He was later found dead.

Paramedics Raymond Peterson of Chicago and Robert Wingo of Bourbonnais, and registered nurse Cheryl Michalek of Dolton, were given special service awards in recognition of their commitment to emergency medical services.

"It takes an exceptional person to choose a career in EMS, for these men and women know their lives and the lives of others may be on the line whenever the alarm sounds," Dr. Lumpkin said.

Two institutions that received commendations from the state were the Des Plaines Fire Department and the Combined Agencies to Reduce Trauma/Local Alcohol Awareness Program Committee of Orland Park. ▲

## Organ donation

(continued from previous page)

only kidneys will be harvested in this manner, but we hope to include the liver and pancreas in the future, and doctors around the country have been interested in creating a program for [cardiac transplants] as well."

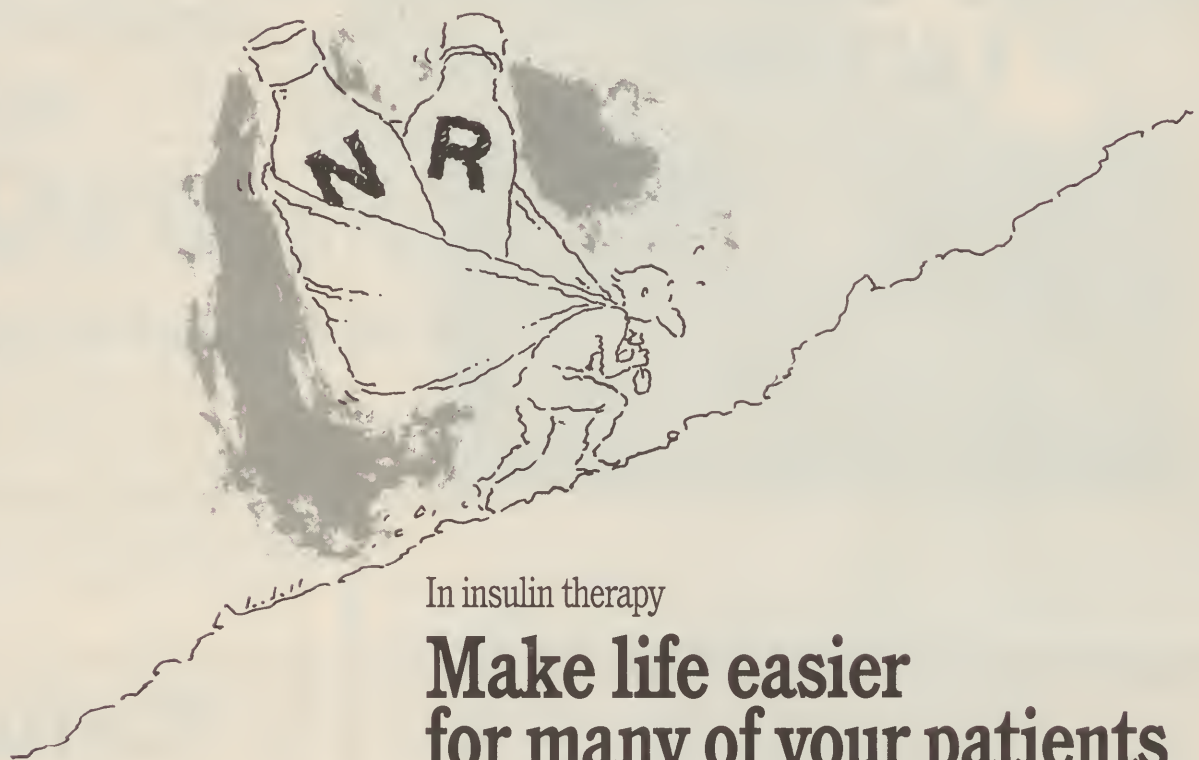
Opponents argue that family members might think trauma physicians won't provide the best care for their loved ones if an organ is at stake. Hopkins stressed that these fears are unfounded: Physicians are in the business of saving patients.

Another concern is that while people understand the concept of organ donation, they might not understand perfusion, especially under the stressful conditions of a death in the family. A study was conducted at Loyola in which 35 families were asked for their permission to perfuse a relative who had just died. All 35 families refused.

"It was just too close to the notification of death," Hopkins said. "People said, 'We don't know what you're talking about.'"

In another Loyola study, six out of seven families consented to organ donation when the patient was perfused without their knowledge.

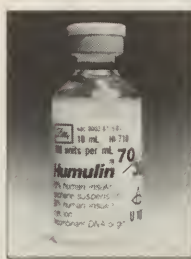
"It gave them time to accept the death, and then they were willing to donate organs," Hopkins said. "Most people are willing to donate a kidney. But it's all we can do to get doctors to think about donations." ▲



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## Universal health

(continued from page 1)

mission members would include state health care department heads and members-at-large appointed by the House and Senate Democrat and Republican leadership. The governor would appoint the commission chairman.

Specifically, the commission would consider coordination of health programs at the federal, state and local levels of government. In addition, the group would recommend ways to "improve accessibility to the Illinois health care system and contain the costs of the system while maintaining quality of care," the amendment says.

Because Young and other sponsors of the universal health care system bill considered Weller's amendment

hostile to the original intent of the legislation, the bill was not called for a vote on the House floor before the legislative deadline.

### Young amendment 'unworkable'

Young's amendment would have been "unworkable" because it still called for government control of the health care system, said Arvind K. Goyal, M.D., Illinois State Medical Society president.

"It is not feasible or desirable to have the government in charge of providing and financing everyone's health care," Dr. Goyal said. "To date, the government's involvement in these areas has resulted in underfunding, cost shifting, increased paperwork, long reimbursement delays and decreased access to care for the so-called 'beneficiaries' of government-administered health programs.

This amendment sought to broaden the government's current questionable record of managing health insurance for all Illinois residents."

The amendment called for implementation of the Universal Health Care Insurance Act by Jan. 1, 1995, as stated in the original legislation. A uniform set of benefits would have been mandated for all residents and the proposal would have required significant tax hikes.

But most of Young's amendment dealt with the establishment of a "Bipartisan Health Care Reform Commission" — using Weller's same language — that would choose between two universal health systems for Illinois. The commission would compare the single-payer, Canadian-style model with a "regulated multiple payers" model. The multiple payers model would not abolish the private health insurance industry in Illinois, as the single-payer system would. It would, however, authorize the state government to set providers' fees and health insurance premiums.

"The regulated multiple payers model is unrealistic," Dr. Goyal told *Illinois Medicine*. "It's nothing more than a bone the sponsors were tossing at the insurance industry. It's not true free enterprise because the state would regulate insurance premium rates, payment rates to providers and total health expenditures."

Under the proposal, the state would also set reimbursement rates for physicians and hospitals, requiring uniform reimbursement across all providers, regardless of which of the two systems the commission recommended.

"Neither option is acceptable," Dr.

Goyal said. "They both are government-controlled, bureaucratic systems that will force rationing of care and raise taxes significantly. The General Assembly should turn its back on these unworkable systems once and for all and consider more positive alternatives that build on the strengths of the current health care system."

*"The General Assembly should turn its back on these unworkable systems once and for all and consider more positive alternatives that build on the strengths of the current health care system."*

In comparison, Young's amendment also called for global budgeting and caps on total health expenditures, concepts Dr. Goyal said were sure to lead to rationing of care, or worse.

"Caps on expenditures could easily lead to health facilities or the entire health care system just being forced to shut down when the money runs out," he said. "That's a situation I cannot tolerate as a physician, and I don't think my patients would stand for it either." ▲

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# CLIA billing coupons on the way

by Tamara Strom

ILLINOIS physicians are beginning to feel the first effects of federal regulation under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The U.S. Health Care Financing Administration, which oversees CLIA, has begun sending billing "coupons" to physicians who operate in-office clinical labs.

When doctors receive these coupons, they should return the completed form, along with a check for the appropriate fee, to receive their registration certificate. Physicians must obtain a registration certificate by Sept. 1 to continue operating their office labs legally. The registration fee is based on the informa-

tion physicians provided to the government on the "109" survey forms they completed last fall.

The billing coupons are being mailed to physicians "on a first-come, first-served" basis, said Walt Kummer, HCFA associate regional administrator, meaning those doctors who returned their 109 forms most promptly will receive their bills and certificates first. Mailing of the coupons will continue throughout the summer, Kummer said. The coupons are easy to complete, he said, adding that physicians can determine how much they owe by matching the proper fee to the category into which their laboratory falls.

Although no deadline technically exists for returning the coupons,

Kummer urged physicians to mail them back as quickly as possible. "It's important they get [the coupons] back in before the Sept. 1 [registration certificate] deadline; they must allow some time for processing."

When physicians receive their registration certificates, all they have to do is "hang it on the wall," Kummer said, and they will be in compliance with CLIA regulations as of Sept. 1. "No additional action is necessary at this point," he said.


Although all physicians are supposed to have already returned the 109 form, if for some reason doctors have not yet done so, "They should get it in now so we can get them a remittance coupon so they can get a certificate by Sept. 1," Kummer said.

After Sept. 1, HCFA will begin the "survey and certification review process," Kummer noted. However, the

agency has no intentions of "going out to inspect a couple hundred thousand labs all at once," he added. And while HCFA plans to begin collecting additional fees for inspections in late summer or early fall, no final decision has been made about what those fees will be, he said.

"What could happen is physicians will be requested to update the information on their [registration] certificate and fees for their inspection will be based on those updates," said Terri Nowakowski, a HCFA program specialist responsible for CLIA.

Physicians can order HCFA 109 forms by calling (410) 290-5850 or HCFA's CLIA hot line at (410) 966-6802. Doctors may also obtain CLIA information from the Illinois State Medical Society at (312) 782-1654 or (800) 782-ISMS. ▲

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Illinois Medicine asked members of the Illinois State Medical Society Auxiliary at its 1992 annual meeting in April:

## What role can Auxiliary members play in the political process?



**Gayle Dustman**  
Bloomington

"Even though many Auxilians have their own careers and have very busy lives, they can be instrumental in giving the time and energy it takes to register voters and distribute materials."



**Carolyn Kobler**  
Rockford

"[Auxilians] can have a good impact on voter registration. In each county we can also make sure physicians are registered. Fifty percent of physicians in Illinois are not registered to vote."



**Sylvia Eberle**  
Roscoe

"The Auxilian is the one who has the time to lobby for the physician, get the word out to the community ... and let the public know how the physician feels on certain issues."

Interviews by Rachel Brown — Photos by Wm. Daniels/The Photo Partners

### OLS

(continued from page 3)

man Services-established reasonable charges. The bill also called for physicians to post the reasonable charges and include them in billings.

**Ambulatory surgical recovery and birthing centers...** Three bills seeking to increase access to care by implementing a pilot program for ambulatory recovery centers and birthing centers failed to advance. The legislation sought to enact the recommendations of Gov. Jim Edgar's Acute Care Task Force, which earlier this year established parameters and guidelines for such model centers. ISMS House of Delegates policy supports the concept of

pilot projects for ambulatory surgical recovery and birthing centers, provided the models fulfill certain requirements, such as meeting state certificate of need criteria, maintaining peer review and creating proper credentialing and quality assurance. In addition, model birthing centers must provide obstetrical care consistent with "recognized obstetrical care guidelines." As the deadline neared, the House adopted an Illinois Hospital Association-backed amendment to an unrelated measure that calls for creation of "alternative health delivery models," keeping the issue alive for the remainder of the session. ISMS is analyzing the amendment to determine if it meets House of Delegates policy.

**Allied health professionals ...** A House bill sponsored by Rep. E.J. "Zeke" Giorgi (D-Rockford) that would have allowed lay midwives to practice in Illinois was tabled in committee. ISMS opposed the legislation.

An amended Senate bill regulating the practice of naprapathy advanced to the House May 22. Although ISMS opposed the measure in its original form because it called for independent practice of naprapathy, the amended bill requires a referral from a physician for a patient to see a naprapath. In addition, physicians must maintain supervision of patients throughout naprapathy treatment. The bill creates a situation similar to that in place for patient relationships with physical therapists. ▲

### Auxiliary

(continued from page 1)

Taylor said, however, that the Auxilians' disappointment at this response did not go unnoticed. "The legislators are very impressed when people come down and meet with them personally instead of just sending threatening letters," she said. "Most [Auxilians] know their legislators. They're not walking in cold asking for a vote on a single issue. Most Auxilians have worked with the legislators in their home district. They are politically aware."

The Auxiliary's lobbying effort against the universal health bills is important, Taylor said, because "The money just isn't there to pay for it and really the access isn't there either. Every person who comes down here to talk about the issue has something to add to the solution or the problem. Everyone has differing viewpoints and they all help shape the legislative agenda."

Increasing Auxiliary political participation is one of President Carol Gapsis' top priorities for this year. "Much of our future will be decided at the hands of government officials, those very legislators we elect to office," Gapsis said in a letter announcing the Auxiliary's day at the Capitol. "For this reason, it is imperative we get involved in the political process at the grass roots level and develop solid working relationships with our legislators."

*"Much of our future will be decided at the hands of government officials, those very legislators we elect to office. For this reason, it is imperative we get involved."*

"We are the 'Force for Change' that will help improve and achieve quality health care for all," Gapsis said, referring to the Auxiliary's theme for the year.

Before heading to the Capitol, Auxiliary members met with two legislators — Sen. Denny Jacobs (D-Rock Island) and Rep. Bill Black (R-Danville) — who explained the opposing pressures in achieving health care reform and the importance of political action. Taylor said both lawmakers gave "excellent" presentations, detailing the political process and "the way it is in Springfield." Auxilians also were briefed by ISMS lobbyists about the effects of redistricting.

To kick off the Auxiliary's "get out the vote" drive, an official from the state Board of Elections explained the nuts and bolts of voter registration drives. The seminar prepared Auxilians to return to their hometowns and hold county-wide registration programs with the Auxiliary's goal of registering all Illinois physicians and members of their families eligible to vote. "We will ask the state medical society to be our sponsor so all the Auxilians who want to can become deputy registrars," Taylor said. Because many physicians and their family members lead busy lives, the county auxiliaries also will promote absentee ballot drives. ▲



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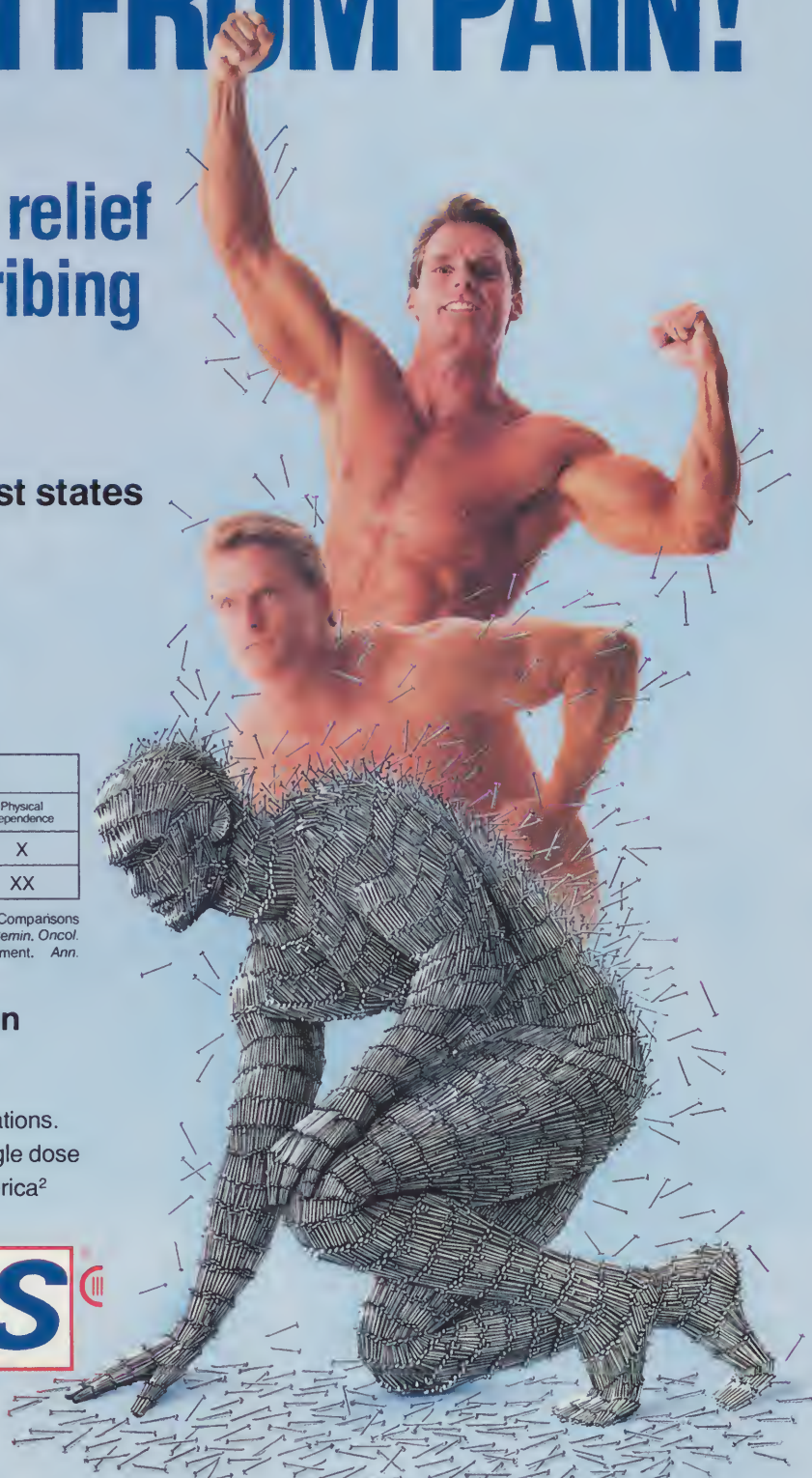
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Revised March 1992

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## Hospitals

(continued from page 2)

Edgar stressed his program protects hospitals that are the "sole providers" for their communities and are struggling financially. In addition, to comply with the federal law on assessment programs, the proposal taxes all hospitals on total revenues, not Medicaid revenues. Some facilities that have low Medicaid patient mixes, but solid bottom lines, will pay more into the system than they will get back in matching funds. This enables the newly fashioned assessment program to spread the burden of treating poor patients across all facilities more effectively, including those facilities that treat low numbers of Medicaid patients.

The plan is the administration's second attempt this spring to achieve federal approval for the provider assessment program. The U.S. Health Care Financing Administration, which oversees Medicaid, May 18 rejected an early payment scheme put forward by the Illinois Hospital Association. The payment plan sought to collect the entire year's assessment from hospitals, nursing homes and facilities for the developmentally disabled before Sept. 30, theoretically allowing the state to recoup the year's federal matching funds before the program becomes illegal Oct. 1.

Although IDPA agreed to send a letter to HCFA asking the agency to rule on the IHA plan, it didn't put

all its eggs into IHA's basket. The department continued working behind the scenes with the governor to prepare the new assessment proposal.

IHA opposes the governor's plan – and all broad-based redistributive provider taxes, for that matter – and is clinging to hope that pressure on HCFA will change the agency's position. "The governor can still lobby in Washington," said Jim Dwyer, IHA spokesman. "We're still advising the governor and the Illinois [Congressional] delegation to lobby everyone in Washington to get that prepayment plan approved for one more year."

But HCFA officials discount that possibility. Only a broad-based provider tax program of some kind will satisfy the federal law, said Charles Hazlett, associate regional administrator for HCFA's Division of Medicaid. "It was thought by our policy people in the central office that the [IHA prepayment] proposal did not meet the intent of the law," Hazlett told *Illinois Medicine*. Although the current Illinois program would cease Sept. 30 if no changes are made, Hazlett said the state technically has until the end of the year to notify HCFA that the changes have been passed by the legislature and signed by the governor. If an acceptable plan is enacted by Dec. 31, the state could be eligible for retroactive Medicaid matching payments from the federal government, he said. ▲

## AIDS task force

(continued from page 1)

said.

The 19-member task force, composed of physicians, dentists, public health specialists, ethicists and private citizens, had over the past six months formulated a draft of recommendations on how best to implement S.B. 999. The intent of the final meeting was to add a fiscal note to the nearly completed document before forwarding a final draft to the governor.

The vote not to fund S.B. 999 was instigated at the urging of Ellen Stimson, one of five public members on the task force. The motion to include a statement in the final draft of the recommendations of the group's opinion that the legislation is "unlikely to prevent even one case of HIV transmission" passed 12-1.

Designed to address public concerns over the transmission of HIV and AIDS in the health care setting, the compromise legislation was passed last summer after reports circulated that a Nokomis dentist had died of AIDS.

The recommendation not to fund S.B. 999 centered on the look-back studies required by the law. The group said such studies are expensive and do not prevent transmission. Look-back studies of more than 15,000 patients conducted by federal health officials found no incidents of health care worker-to-patient transmission of HIV. The task force said

HIV-AIDS-specific funding should be allocated instead to education and prevention programs.

Directing funds for look-back studies could also endanger funding for other programs endorsed by the group, such as an expert panel to review and counsel HIV-positive health care workers, analysts say.

At previous task force meetings, the issue of funding had not been addressed as members discussed such issues as notification, confidentiality, education and prevention. Some members had questioned the notification requirements, but were determined to work with the group to find the best implementation method possible.

Dr. Ramirez called for a "re-examination of the problem under a more detailed, serene analysis. "The AIDS crisis is a constantly evolving situation. Problems need to be looked at from different points of view," he said.

In this vein, Dr. Ramirez plans to suggest to the governor in his letter accompanying the recommendations the need for ongoing input from an advisory group that could meet once or twice a year to address new information and problems. He said that while the appointment of members would be up to the Illinois Department of Public Health, he would like to see the members of the current task force included, and suggested that legislators might also be included. ▲

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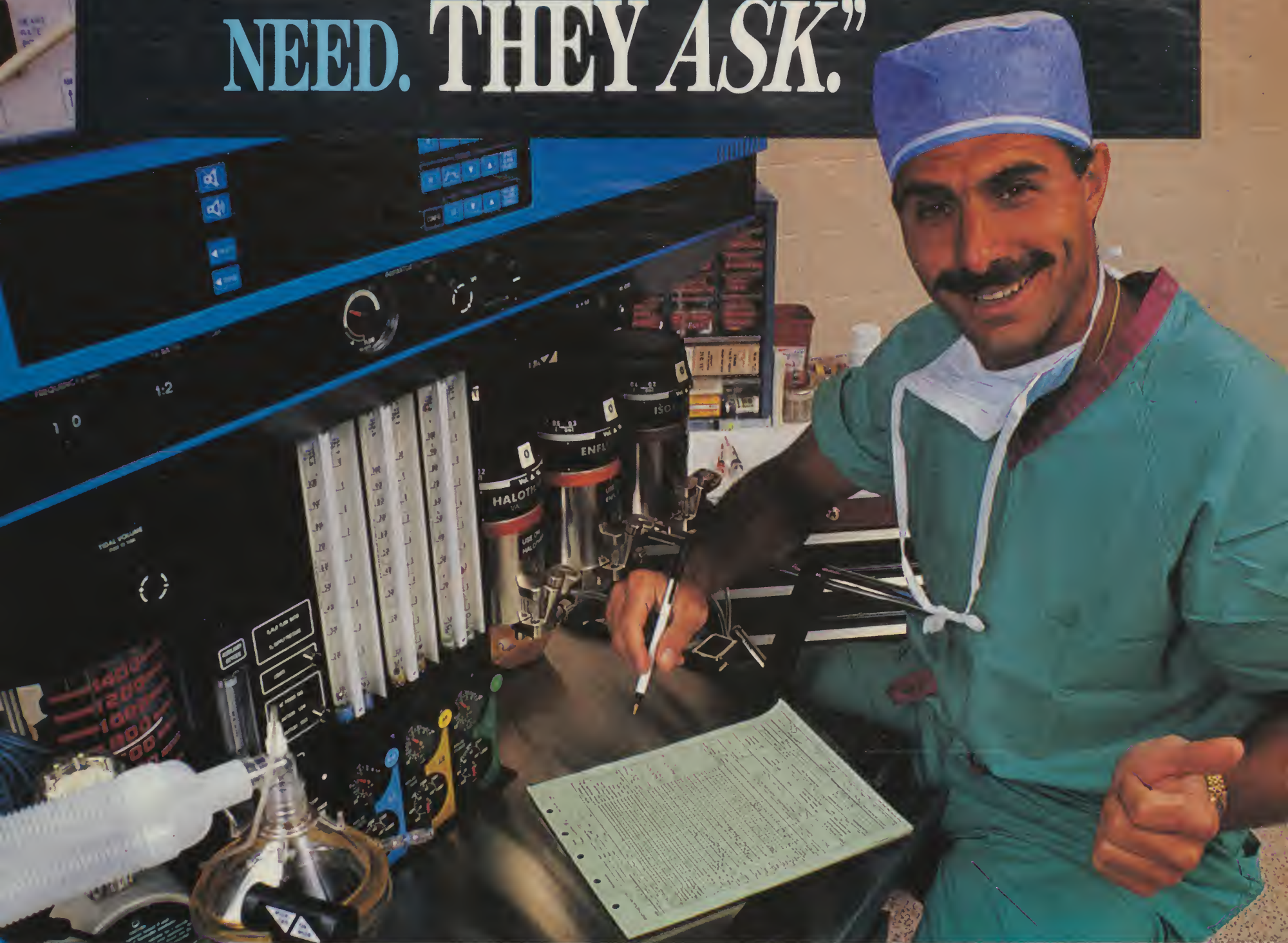
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### BRIEF SUMMARY

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**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

**References:** 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil In Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
G.D. Searle & Co.  
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Skokie, IL 60077

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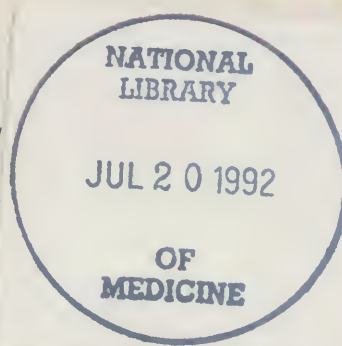
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# Illinois Medicine

June 19, 1992

ILLINOIS STATE MEDICAL SOCIETY



How to choose a waste hauler.....8

ISMS participates in AMA/Gallup study

## Illinois adults favor tort changes, health care reform

by Tamara Strom

A RECENT GALLUP study surveying Illinois adults yielded promising results about the mood of the electorate in achieving reasonable health care reform. Perhaps most encouraging are the responses showing that Illinois residents favor malpractice reform, including caps on non-economic damage awards.

The poll, one of a series of periodic surveys Gallup has undertaken for the American Medical Association, surveyed adults nationwide in March on health issues. An additional 400 Illinois adults were asked questions submitted by the Illinois State Medical Society. The Society's questions were "piggybacked" onto the regular AMA survey; from time to time AMA offers single states the chance to participate in its regular polls. The margin of error for the sample of Illinois adults is  $\pm 4.9$  percent.

"We were delighted to participate in the most re-



*Illinoisans' attitudes toward malpractice lawsuit awards:*

**Do you think the amount of money awarded to patients in malpractice suits is usually too high, not enough or about the right amount?\***

	3/92	8/89	9/84
<b>Too much</b>	<b>53%</b>	<b>43%</b>	<b>34%</b>
<b>Not enough</b>	<b>9%</b>	<b>17%</b>	<b>11%</b>
<b>About the right amount</b>	<b>33%</b>	<b>27%</b>	<b>39%</b>
<b>Don't know - n/a</b>	<b>6%</b>	<b>13%</b>	<b>16%</b>

\*400 Illinoisans were asked this question in a March 1992 Gallup/AMA public opinion survey.  
Source: Illinois State Medical Society.

cent AMA-Gallup health care poll," said Jere E. Freidheim, M.D., chairman of the ISMS Board of Trustees. "It was a cost-efficient way for us to find out what people

in Illinois are thinking about health care. Participating in an already commissioned survey enabled us to more effectively serve our members. By sharing the re-

sults, we can also help elected officials understand what Illinois adults expect when it comes to health care."

The survey results indicate the general public is developing a thorough understanding of the cause-effect relationship between medical malpractice issues and spiraling health care costs. When asked to cite reasons for increasing health costs, 19 percent of respondents answered "mal-

practice insurance costs" - the No. 1 answer. In addition, 71 percent of Illinois adults felt medical malpractice has a "great deal" of effect on the cost of health care.

On the subject of caps, 70 percent responded that a limit should be placed on non-economic awards. This is up from the 62 percent who favored caps in 1989, the last time ISMS surveyed Illinois adults on the topic. Only 28 percent of those surveyed said no limit should exist. In addition, 53 percent said current jury awards are too high. Thirty-three percent said the amount is about right, while only 9 percent said jury awards are too low. When

(continued on page 14)

*Complying with the ADA*

## Establish protocols to ensure access to services

by Kevin O'Brien

IMAGINE THE following scenario: You are a physician seeing a new patient. The patient is hearing-impaired, but you do not know that and the patient did not request any special arrangements when scheduling the appointment. The patient keeps the appointment, accompanied by an interpreter who "signs" for you and the patient. The ex-



amination concludes and your office assistant presents the patient with a bill for \$32. The interpreter then presents your office assistant with a bill for \$35. Do you have to pay? Probably.

The above scenario is not at all farfetched. It has already been played out in at least one Illinois physician's office, and the American Medical Association reports

similar incidents have occurred throughout the country.

With implementation of the landmark Americans with Disabilities Act, signed by President Bush in July 1990, all physicians need to review their policies and protocols to ensure not only that their facilities are accessible, but that their professional services are too. In the case of hearing-impaired and visually impaired people, that means physicians need to think about providing "auxiliary aids and services."

Specifically, the regulations issued July 26, 1991, to implement Title III of the ADA state that physicians must ensure that no patient is discriminated against "because of the absence of auxiliary aids and services," unless providing those aids or services "would fundamentally alter the nature of the goods, services, facilities, privileges, advantages or

(continued on page 17)

*Exclusive interview*

## Oregon plan could begin in October

by Kevin Kelleghan

THE STATE OF Oregon could begin its controversial "rationing" health care plan as early as October. Implementation hinges on the federal waivers to Title XIX of the Social Security Act and a decision is expected by mid-June, Oregon State Senate President John Kitzhaber, M.D., told *Illinois Medicine* May 16.

The four-term Senate president was in Rockford to address the 53rd Annual Theodor Lang May Day Clinic. The two-day annual clinic, sponsored by the UIC College of Medicine at Rockford and St. An-

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## It's not time to renew ... but have you moved?

If so, the Illinois Department of Professional Regulation may be looking for you. While you do not need to renew your medical license until next year, keeping the department informed of your current address will help them remind you to renew when the time comes. Turn to page 13 to find a change of address form that you can clip, fill out and send to the department. You must notify the department of an address change in writing; phone changes will not be accepted. ▲

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## News Briefs

### AMA Board recommends no dues increase

The American Medical Association's Board of Trustees is recommending a 1993 budget that does not include a dues increase. If the budget is approved by the House of Delegates at the upcoming AMA annual meeting June 21-25, dues will remain \$400 a year for active members, the fifth year at that level.

"Even though association operating costs continue to rise with inflation and with meeting the ever-expanding needs of physicians and medicine to be represented to Congress, to the federal bureaucracy, to the public and other groups as well as to physicians themselves, the AMA board is determined to not raise dues," according to an AMA fact sheet.

The board recommendation is based in part on the success to date of the AMA's MD-2000 program, a membership recruitment and retention campaign targeted at having 50 percent of the nation's practicing physicians on the membership rolls by the year 2000. In addition, the AMA notes, the board and staff continue to explore new avenues for non-dues revenue.

Last year's strategic Plan of Action will continue into 1993, the board said. "All priority issues and activities which do not directly relate to the major strategic issues are being reduced or eliminated entirely as resources and staffing are redirected toward the high-priority areas."

AMA leadership also cautioned state and local medical societies against raising dues because of the poor economy and increased government- and third party payer-imposed hassles facing physicians. The Illinois State Medical Society House of Delegates voted in April to keep state membership dues at the same level for the 1993 dues year.

### UIC College of Medicine begins radiology residency

The UIC College of Medicine at Peoria will begin a radiology residency program July 1. The four-year program will accept two residents each year, with the residents training mainly at Peoria's Saint Francis Medical Center. The program was accredited in April by the Accreditation Council for Graduate Medical Education.

"The implementation of this program represents a major undertaking and is the culmination of an intensive effort that began several years ago," said Terry Brady, M.D., residency program director. "The process began with the recruitment of several new radiology subspecialists to Peoria and the expansion of our clinical research. The next step was to develop a complete four-year curriculum that reflects our commitment to train residents to become fully qualified and competent radiologists."

The curriculum is based on guidelines set by the American Board of Radiology, which offer residents subspecialty rotations in all 14 divisions of radiology. These include: chest, gastrointestinal, genitourinary, skeletal, mammography, emergency room, pediatric, nuclear, neuroradiology, angiography/interventional radiology, cardiac, CT, magnetic resonance imaging and sonography. Residents also will be required to undergo training in radiobiology, radiologic physics and pathology.

Among the program highlights are fourth-year elective subspecialty training and rotations at the Armed Forces Institute of Pathology in Washington, D.C. The UIC College of Medicine currently operates 12 other graduate residency programs. ▲

— by Tamara Strom

## Postcard campaign targets universal health proposal

by Ginny Thiersch

FOLLOWING AN Illinois State Medical Society-sponsored media blitz attacking the "universal" health care proposal, ISMS is launching a patient postcard campaign to keep the pressure on state legislators who might still be considering supporting the concept.

Postcards are available for distribution through physicians' offices. Patients can sign cards to be sent to their state representatives and senators for mailing by the office.

The bright, multicolored cards proclaim "Universal health care doesn't measure up!" They carry the message, "A Canadian-style health care system in Illinois would increase our income taxes and taxes on employers. At the same time, it would reduce access to health care."

The drawing of a ruler on the card ties the message to the Society's "Ten Principles for Health Care Reform" adopted at the ISMS House of Delegates annual meeting in April. The graphic was used on handouts distributed at more than a dozen editorial board briefings across the state in May and June. ISMS President Arvind K. Goyal, M.D.; President-elect Arthur R. Traugott, M.D.; and several members of the ISMS

Board of Trustees called on newspaper editors and editorial page staffs from Belleville to Rock Island to Decatur to urge the papers to oppose universal health.

"While the current system is not without fault, it has provided the best medical care in the world to millions of patients for decades," Dr. Goyal told editors at the *Chicago Tribune*, *Chicago Sun-Times*, *Crain's Chicago Business* and the *Daily Herald* in Arlington Heights. "It would be a horrible mistake to scrap it."

While the bills supporting universal health care failed to move out of their respective House and Senate chambers, the concept can still be amended to other legislation now being considered in Springfield. Another proposal, supported by State Treasurer Patrick Quinn, would put a so-called "free" taxpayer-funded health care plan on the November ballot as an advisory referendum.

An office poster delineating the 10 ISMS principles for health care reform will be distributed in the next issue of *Illinois Medicine*, and a sample postcard is included in this issue. To order quantities of the postcard, call the ISMS public relations department at 312/782-1654 or 1-800-782-ISMS. ▲

## Deadlines for OSHA are here

by Tamara Strom

JUNE 6 AND July 6 are dates to remember for Illinois physicians. They are the last two deadlines for compliance with OSHA rules. As outlined by the U.S. Occupational Safety and Health Administration earlier this year, the staggered deadlines have given physicians several months to comply with the federal rules on reducing risks of transmission of bloodborne pathogens.

As of June 6, physicians should have implemented proper record-keeping protocols and a training program for their employees who may come in contact with bloodborne pathogens during the course of their workday. By July 6, the final OSHA compliance deadline, physicians must be providing infection-control barriers — such as masks, gloves and eyewear — and must have begun vaccinating at-risk employees against the hepatitis B virus.

The June 6 deadline required physicians to have in place a detailed employee training program in risk reduction and universal precautions. Using the barrier techniques prescribed by the tenets of universal precautions is required with all patients, not only those with an infectious disease such as HBV or HIV.

The training must be provided to employees at no cost and during

working hours, the OSHA guidelines state. Re-education is required annually and whenever an employee's job changes in a way that offers new opportunities for exposure. Specifically, the training must educate employees about the symptoms of bloodborne diseases and how they are transmitted; explain where the office's written exposure control plan is located and how it can be accessed; provide information on properly using, decontaminating and disposing of protective equipment; instruct workers what to do in case of an exposure emergency, including what steps must be taken for postexposure follow-up; and explain the proper use of warning labels. Employees also must be given the opportunity to ask questions about what they are taught. This list of provisions is not all-inclusive; physicians should refer to the standard to ensure they are providing all necessary training.

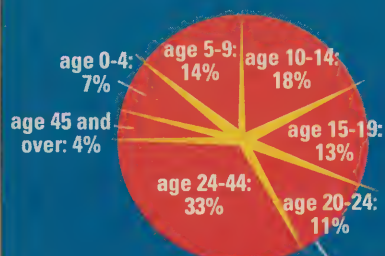
Record-keeping protocols also are delineated under the rules. Each employee must have a medical record on file that includes the worker's Social Security number and whether the employee has received the hepatitis B vaccine or declined the vaccination. In the event of exposure, medical files should include notes on examinations, tests and

(continued on page 16)

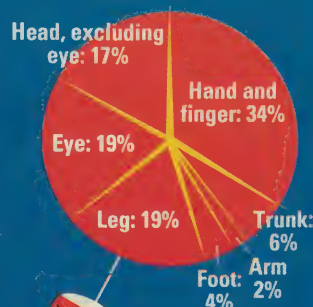
## Physician Facts

### Fireworks injuries in the United States\*

#### Fireworks injuries by age of victim



#### Fireworks injuries by body part injured



\* June 23 - July 20, 1990, only.

Source: Consumer Product Safety Commission National Electronic Injury Surveillance System; National Society to Prevent Blindness.

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# UNIVERSAL HEALTH CARE DOESN'T MEASURE UP!

A Canadian - style health care system in Illinois would **INCREASE** our income taxes and taxes on employers. At the same time, it would **REDUCE** access to health care.



Dear Legislator:

I agree with my doctor that a government - run, taxpayer funded health care system in Illinois would hurt more than it would help.

Let's not throw away the system that gives us the finest medical care in the world -- let's work to improve it for all the citizens of our state.

Illinois physicians want to improve and strengthen health care in our state. I urge you to work with them to bring the best in our health care system to more people.

(Sign here)

PLACE  
STAMP  
HERE

(Write in Legislator's Name)

State House

Springfield, IL 62706



# Health measures advance in legislature dominated by budget woes

by Tamara Strom

IN A LEGISLATIVE session dominated by election-year posturing and the ever-lengthening shadow of the state's fiscal crisis, several health care-related measures are quietly advancing. The following bills passed from their houses of origin last month and now are being considered in committee or on the floor of the alternate house.

**Resident work hours ...** An amended version of S.B. 1692, which cleared the House Health Care Committee, would regulate resident and intern work hours. The bill is now up for consideration on the House floor. Although the Illinois State Medical Society opposed the bill in its original form, the current amended version mirrors organized medicine's position that medical bodies, such as the Accreditation Council for Graduate Management Education, should be responsible for regulating the profession.

**Clinical professional counselors ...** An ISMS-opposed measure sponsored by Sen. Emil Jones, Jr. (D-Chicago) and Rep. Terry A. Steczo (D-Country Club Hills), S.B. 2056 would allow the independent practice of clinical counselors, provided they are properly licensed by the state. A similar measure passed the General Assembly last year but was vetoed by the governor.

**Tuberculosis testing requirements ...** H.B. 3856, sponsored by Rep. Clem Balanoff (D-Chicago), amends the state's School Code to require that TB tests be routinely included with all medical examinations for Illinois school children. The legislation is now before the Senate Rules Committee. ISMS supports the bill.

**Fibrocystic coverage ...** Several bills dealing with women's health issues have garnered support this session. Now before the Senate, H.B. 2825 calls for a change in the Insurance Code to restrict limits and exclusions contained in accident and health insurance policies for women with fibrocystic conditions. The ISMS-supported legislation is sponsored by House Minority Leader Rep. Lee A. Daniels (R-Elmhurst); Rep. David Deets, M.D., (R-Dixon), the only physician member of the General Assembly; and Sen. Jack Schaffer (R-Crystal Lake).

**Breast implant bill gutted ...** A bill sponsored by universal health care advocates Sen. Margaret Smith (D-Chicago) and Rep. Anthony L. Young (D-Chicago), S.B. 1645, was gutted in the House Health Care Committee. The bill had called for increased dissemination of information about breast implants. Sources say S.B. 1645 may become a vehicle for single-payer universal health care legislation.

**Women's health needs ...** Also before the House Health Care Committee is S.B. 1647, sponsored by Smith and Rep. Donne E. Trotter (D-Chicago). The measure directs the Illinois Department of Public Health to designate a staff member to handle women's health needs that are either not currently addressed or not addressed adequately by the de-

partment. ISMS has no opposition to the amended version of the legislation.

**Mammography ...** Another Smith bill, S.B. 1760, encourages mammography standards. The ISMS-supported measure would require IDPH to include American College of Radiology-recommended standards in its breast cancer program summary. The bill's House sponsor is Rep. Barbara Flynn Currie (D-Chicago.)

**Gun accessibility ...** A bill sponsored by Sen. William A. Marovitz (D-Chicago) and Rep. Lee Preston

(D-Chicago) would amend Illinois' Criminal Code to make keeping a loaded gun in reach of children under age 14 a misdemeanor if a child finds the gun and hurts or kills someone with it. ISMS House of Delegates policy adopted at the 1992 annual meeting supports the bill provisions in concept. ISMS supports the bill.

**Lead poisoning prevention ...** Rep. Ann Stepan (D-Chicago) is sponsoring H.B. 3638, which would require IDPH to compile comprehensive records documenting reported cases of childhood lead poisoning. The

ISMS-supported bill is under consideration by the Senate.

**AIDS testing of minors ...** H.B. 4056 exempts health care providers from criminal penalties for notifying or failing to notify the parents or legal guardian of a child testing HIV positive. The measure – sponsored by Rep. Monique Davis (D-Chicago) and Smith – would require physicians to encourage the child to speak to his or her parents about the test result before the doctor or other health worker could contact the child's parents. ISMS has no opposition to the bill. ▲

## Blue Cross Blue Shield



# REPORT

## FOR *Illinois Physicians*

### PIN VS. UPIN

This article is intended to clarify the difference between a PHYSICIAN IDENTIFICATION NUMBER (PIN) and a UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN).

#### Physician Identification Number (PIN)

PINs have been assigned to physicians in the option II group category, including hospital departments, for identifying physicians individually. The six-digit PINs begin with letters "L" or "P" and apply only to physicians whose services are billed under a shared provider number, either for a group (i.e., two or more physicians) or hospital department. The PIN identifies a specific physician within the group or department.

Each PIN is tied to a payee. Use of the wrong PIN for the performing physician can direct payment to the wrong group, in the wrong amount. For hospitals, use of a performing physician PIN from the wrong department can cause payment under the wrong profile. PIN errors also can result in delays or denials. For these reasons, verification of the PIN is important.

On claims from entities that identify physician members by PINs, the PIN of the performing physician is reported in field 24-K of the HCFA-1500 form. (The group name and group provider number are reported as usual in field 33) If the claim is submitted by terminal or terminal emulator, the PIN for the performing physician is listed on the second screen in the field for "provider number". If the claim is filed on tape or from computer to computer, the performing physician's PIN is listed in the field designated for the "performing physician or supplier code".

PINs are not assigned to physicians in solo practice or to groups that bill with an individual provider number for each physician member. In these instances, a PIN is unnecessary because each physician is assigned a six-digit all-numeric provider number identifying that physician only. The provider number is reported in field 33, and field 24-K is left blank.

#### Unique Physician Identification Number (UPIN)

The 1985 Consolidated Omnibus Budget Reconciliation Act requires that a UPIN be established for each physician providing services payable by Medicare. A National Registry of Physicians has been established to develop and maintain a master file of all such physicians and to assign a UPIN to each. The UPINs begin with a letter and are followed by five numbers. The use of the UPIN (field 17A, HCFA-1500 form) to identify the referring or ordering physician on claims for consultations, therapies, tests, prosthetic devices, and durable medical equipment is effective November, 1990.

\*A referring physician is one who requests an item or service for the beneficiary for which payment may be made under the Medicare program. A request might include a consultation with a specialist physician (other than a pathologist who furnishes or personally supervises any test or procedure) or establishment of a plan of care which includes the provision of an item or service.

\*An ordering physician is one who orders non-physician services for the patient, such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, or the technical component of diagnostic tests.

Effective January 1 1992, all claims to Part B for services resulting from a physician's order or referral must include the name and UPIN of the ordering/referring physician. Claims for diagnostic and consultative services and durable medical equipment will be routinely edited for a UPIN. All claims from laboratories, durable medical equipment suppliers, radiologists, and consulting physicians are required to report an ordering/referring physician.

If any of these items or services resulted from a self-referral (the ordering and performing physician are one and the same), the performing physician's UPIN must be shown in field 17A of the HCFA 1500 form.

**Example 1:** Dr. Smith sees an established patient and does a blood draw and a urinalysis in his office. Dr. Smith bills Medicare for an office visit (99213), a blood draw (36415), and a urinalysis (81000).

Because Dr. Smith ordered the "tests" and is also the performing physician, he must show his UPIN in field 17A.

**Example 2:** Dr. Smith sees a patient who has been referred to him by Dr. Jones. He bills Medicare for a consultation (99242), a blood draw (36415), and a urinalysis (81000). Again, the "tests" are done in his office.

Because this patient was referred to Dr. Smith, and the tests done were a direct result of the referral, Dr. Jones' UPIN should be shown in field 17A. (Currently, only one UPIN should be shown in field 17A).  
(6/19/92)



## Editorial

## You've got a friend

**T**he primary function of the medical society is to serve as an advocate for its members and for the public health. That advocacy mission is not confined to the halls of the state Capitol, although a great deal of what happens there on your behalf is advocacy. You and your patients are represented as well in the state agencies whose activities impact on you and your practice; in the media, advocacy on your behalf is both reactive and proactive – ask Dr. Goyal and the trustees and officers who crisscrossed the state last month persuading editorial boards of our position on national health.

To the AMA, to third party payers, to decision makers in Washington, the advocacy efforts of the Society are directed to you, your interests, your patients and the public health.

And now, you've got a friend in court as well. And Dr. James Vest, the newest of medicine's heroes, has got a friend in jail.

Dr. Vest is the St. Clair County physician who was jailed, along with his attorneys, for refusing to answer egregiously improper questions during a deposition scheduled before a lawsuit had even been filed. The plaintiff's attorney should have been required to purchase a fishing license before he began the proceeding; it was clear he wanted to use information gleaned from Dr. Vest to meet the certificate of merit requirement.

The Exchange-provided attorney who accompanied Dr. Vest to this deposition rightly advised him not to answer the improper questions being asked of him. For her trouble, she too was jailed. Dr. Vest's personal attorney rushed to help. He was thrown in jail also.

As far as the medical society is concerned, their eventual release from jail more than five hours later, on a writ from the Court of Appeals, was not the end of the story. No way.

ISMS will petition for permission to file an *amicus curiae* ("friend of the court") brief when the case is heard. Why? Because it looks to ISMS like the St. Clair County incident constitutes nothing less than a full-fledged frontal attack on the certificate of merit requirement, a requirement important in keeping the number of malpractice filings under control and a requirement recently upheld by the state Supreme Court.

It's important that Dr. Vest stay out of jail, so he can do what doctors do: take care of patients. And it's important to all of the other physicians in Illinois who look to ISMS to stand up for them.

Even in the jails of St. Clair County, you've got a friend.

## See you in July

**A**s is our custom, we will not publish a July 3rd issue of *Illinois Medicine*. Look for your next issue, dated July 17, to feature highlights of the current session of the Illinois General Assembly and the June 21-25 annual meeting of the American Medical Association House of Delegates.

In the meantime, have a safe and enjoyable Independence Day. ▲



## President's Column

## What's good for the Blues must be good for quality



Arvind K. Goyal, M.D.

"Begin your story well," author Ian MacLaren counseled a group of budding writers. "It's half the battle." And he gave the example of a young man who, desiring to marry, obtained a favorable hearing from his sweetheart's father by opening the interview with these words: "I know a way, sir, whereby you can save a lot of money."

That is how Blue Cross and Blue Shield of Illinois (BC/BS) tried to sell their physician profiling program. They recently told the media of their plans to develop a "system" to track Illinois physicians' practice patterns. They apparently found some information just sitting in their "computerized data bank" doing nothing, from which they will synthesize "physician profiles." Those profiles will measure differences in physicians' practices. They will be able to match the type of office visits with diagnostic services, hospital admissions, surgeries and specialty referral rates. This way, they'll be able to tell the good from the evil. This activity, they would like you to believe, will improve the quality of medical care, and save a lot of money. Noble indeed.

The press release obviously got more than just attention. Public inferences varied: There must be many bad doctors out there! Quality must not be as good as it looks. No wonder health care costs are soaring! Why else would they need a new untested program? This is what the public understood.

The press release *didn't* say that an overwhelming majority of physicians already do a good job. It didn't say that no amount of regulation could improve what is already a very high quality of medical care. It will slow your doctor's day a bit, though. It may raise your doctor's paperwork hassles, and paranoid feelings – however well-founded! What's so bad about requiring a narrative response if the computer wants to learn more? That shouldn't cost anything more to the patient or the insurer. Time is no object when it isn't your own time.

What they didn't say but meant all along was that the money they might save will be for themselves! By getting some play in the media with this story, they might increase their market share if a few new accounts signed on. Every little bit helps in this dog-eat-dog world! And by putting some pressure on those physicians who refer patients for surgery, MRI scans, cardiac catheterization, etc., maybe their bottom line will expand! The more they say it isn't the money, it's the money.

They failed to explain that the funds that will be required to start up this pro-

gram would easily come out of the ever-increasing huge premiums charged our patients or employers paying on their behalf. And nobody thought it was necessary to clarify that if some savings did occur, by act of God, where that money would go. Will it show as a rebate on the next premium notice, or will it just be added to the corporate bottom line?

And there were other issues they did not consider, ones they would rather not hear. For example, services required by contract between BC/BS and subscribers may generate demand for a particular test or service, necessary or not. Should that be included in a physician's profile? The practice mix of an internist with a high proportion of terminally ill and poor patients, and the obstetrician with higher than average high-risk deliveries may generate skewed data. And if the profiled physician disagrees with the conclusion reached via this profile, who is to hear an appeal or arbitrate? Shouldn't somebody worry about the potential abuse or misuse of data if just handed over or sold to the media, the hospitals or the plaintiffs' attorneys!

Your House of Delegates recently debated this fall from grace, and adopted a resolution expressing "deep concern" about the physician profiling program. The Blues were asked to shelve it, pending further discussions with ISMS, and were also urged to share their findings with ISMS for purposes of physician education. The House also reaffirmed its opposition to economic credentialing, a real possibility with programs like this!

I am pleased to report that the "deep concern" on your behalf has already been expressed at a recent meeting of the ISMS Third Party Payment Processes Committee with Dr. Arnold Widen, medical director of BC/BS. I am anxiously awaiting his response to the concerns raised. And I sure hope that information comes soon – that is, before the Blues announce their next "wonderful" program to the press! ▲

ARVIND

Arvind K. Goyal, M.D.  
President

## Illinois Medicine

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## Guest Editorial

## Health care reform: The status quo is unacceptable



by M. LeRoy Sprang, M.D.

*"The world hates change, yet it is the only thing that has brought progress."*

— Charles F. Kettering

Decades of scientific and technological advances have made the United States the world leader in health care. Our standard of care is the envy of the rest of the world. Our system provides superior technology, freedom of choice, personalized care, and impressive medical education and research. But our system also has flaws. Thirty-five million Americans do not have health insurance. Many individuals believe the relentless climb in health-care costs is no longer tenable. Senate majority leader George Mitchell said, "The rapidly rising cost of health care cannot be sustained by families, by business, or by the nation as a whole."

Broad-based calls to reform our health-care system are being heard loud and

clear. In Washington, many proposals are being discussed, including President Bush's, the Democratic leaders' "pay or play" that would require employers to provide health insurance or pay into a national system to cover the uninsured, small group-insurance reform, managed competition with a public sponsor, and national health insurance.

In Springfield, House Bill 2774 and Senate Bill 1495 were voted out of committee and sent to the floor for further action. These two bills, if enacted, would create a "Canadian-style" health-care system in Illinois.

In addition to the 35 million uninsured Americans, middle-class Americans are concerned. They are worried that if costs continue to rise faster than the Consumer Price Index, their employers may discontinue their health insurance or may pass more of the cost of premiums onto them. They also are concerned that if they change jobs, preexisting conditions may prevent them from getting new health insurance. And, worst of all, what happens if they are unfortunate enough to lose their jobs?

As physicians, we recognize our patients' concerns. We recognize that there are problems of access for some patients, and we want to be part of the effort to address local, state, and national problems in health care. We want to improve the current public-private partnership in health care rather than create a radical, new, single-payer, government-run health-care system. We recognize the status quo is unacceptable. We encourage and are prepared to work for appropriate change. We believe change in our system must ensure defined health-care coverage for all Americans. Change must preserve freedom of choice for both patients and physicians. Change also must moderate the causes of spiraling increases in health-care costs. Change would include implementing wellness/prevention programs; decreasing administrative costs; health-insurance reform, like the

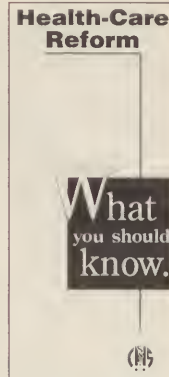
establishment of risk pools; and significant liability reform.

Physicians believe all Americans, regardless of their income, should have basic health care available to them. We believe this basic health care should be affordable and portable. To accomplish this, most Americans believe that America should reform, not replace, its current health-care system.

Physicians believe nationalized health care is the wrong direction for America. Wouldn't it be ironic for the United States to centralize its health-care system when the rest of the world is realizing centralized government control is a failure? Other countries are looking to the United States for help. A government-controlled universal health-care system would cause in the short term a decrease in quality of care for 87 percent of Americans, and in the long term a decrease in quality of care for all. A decrease in new technology, new drugs, and new procedures would be inevitable. Robert Reischauer, director of the Congressional Budget Office, said, "A single-payer system would cost the government 75 percent more than it is now paying for health care and would result in the slower development and distribution of technology."

In Canada, for example, such high-tech equipment as CT scans and MRI machines is scarce. Patients can wait up to a year for sophisticated procedures, like coronary bypass surgery or hip replacements. Forty children requiring heart surgery were discharged, untreated, from the Hospital for Sick Children in Toronto because of lack of facilities.

Canadian physicians must ration even less costly preventive care. Canadian women are only eligible for Pap smears once every five years, and routine screening mammography is unavailable, because Canada doesn't have sufficient



mammogram machines. In spite of the long lines for surgery, shortage of hospital beds, and general deterioration of the system, Canada is having serious difficulties controlling its health-care bill. For example, Ontario's health-care bill now consumes one-third of the provincial budget. From 1970 to 1990, the increase in the cost of health care is higher in Canada than it is in the United States.

For all these reasons, the issue of health-care reform is a major concern for physicians and our patients. It demands our attention because the very existence of medicine as we know it hangs in the balance. Political leaders elected in November 1992 will enact significant health-care legislation in 1993 and 1994.

Physicians have an ideal opportunity to disseminate information. We can talk to our patients in our offices and clinics. To make dissemination of information even easier, CMS has written a brochure on health-care reform containing overviews and comparisons of several major health-care proposals. A portion is reprinted below. Ideally, the brochure should be ordered from CMS, handed to the patient by the physician, and then discussed. At a minimum, each physician should review the information in the brochure, order a quantity of them from CMS, place them in the reception area, and encourage patients to read them.

For both pragmatic and ethical reasons, change does need to occur. We need to be sure the members of the public, who are our patients, have the facts so they can make informed decisions on the changes they want. The facts are on our side. We can only lose if we don't do our part. We need to discuss the issues with patients, political leaders, and other interested groups. We all need to be committed, because the health care of future generations of Americans is at stake. ▲

*Dr. Sprang, an obstetrician/gynecologist who practices in Evanston and Glenview, is president of the Chicago Medical Society and an ISMS Third District Trustee.*

## Who pays?

Health Care Proposals	Overview	Cost to Patient	Cost to Employer	Government/Funding source	Services	Freedom of choice	Malpractice reform
<b>Health Access America</b> <i>American Medical Association's proposal</i>	<ul style="list-style-type: none"> <li>Preserves strength of current system and improves it</li> <li>Defines health care insurance coverage for Americans</li> <li>Increases access, maintains quality</li> <li>Community rating*</li> <li>Contains mechanisms for cost reduction</li> </ul>	<ul style="list-style-type: none"> <li>20 percent copayment for most services</li> <li>Individuals who pay 100 percent of insurance premiums can deduct it from taxes</li> </ul>	<ul style="list-style-type: none"> <li>Mandates employer provide private insurance for all full-time employees</li> </ul>	<ul style="list-style-type: none"> <li>Tax credits to employer</li> <li>Patient-employer premiums</li> <li>Public funding of un- and underinsured</li> <li>Medicaid reform</li> </ul>	<ul style="list-style-type: none"> <li>Basic benefits package, plus prescription drugs</li> </ul>	<ul style="list-style-type: none"> <li>Yes, for private physician</li> <li>Yes, for hospital</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Caps on non-economic awards</li> <li>Periodic payments</li> <li>Reduces health care costs</li> <li>Eliminates double recovery</li> </ul>
<b>Health America</b> <i>Democratic proposal</i>	<ul style="list-style-type: none"> <li>Increases access</li> <li>Increases taxes and bureaucracy</li> <li>May hurt small businesses</li> <li>May lead to nationalized health care</li> <li>May cause unemployment</li> </ul>	<ul style="list-style-type: none"> <li>May pay 20 percent of insurance premiums</li> <li>May face deductibles and coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>Pays 7 percent to 9 percent of payroll tax or pays at least 80 percent of insurance premiums — "pay or play"*</li> </ul>	<ul style="list-style-type: none"> <li>Taxes increase</li> <li>Patient-employer premiums</li> <li>Medicaid reform</li> </ul>	<ul style="list-style-type: none"> <li>Basic benefits package, plus preventive medical care</li> </ul>	<ul style="list-style-type: none"> <li>Yes, but may be limited by HMO</li> <li>Emphasizes managed care — HMO</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Authorizes grants for states to implement reform</li> <li>Alternative dispute resolution, like arbitration</li> </ul>
<b>Comprehensive Health Care Reform</b> <i>President Bush's proposal</i>	<ul style="list-style-type: none"> <li>Accessible and efficient health care</li> <li>No "job lock"*</li> <li>Less bureaucracy</li> <li>No denials of preexisting conditions* for group policies</li> <li>Large regional health care networks</li> <li>Community rating*</li> </ul>	<ul style="list-style-type: none"> <li>Tax credit or voucher will be given on a sliding scale to provide financial incentives for uninsured to buy health insurance</li> <li>Individuals with higher incomes can deduct premiums from taxes to a certain amount</li> </ul>	<ul style="list-style-type: none"> <li>Businesses will be pooled to reduce costs</li> </ul>	<ul style="list-style-type: none"> <li>Voucher for a \$3,750 tax deduction toward insurance premiums, or tax credits, each of which is phased out above a certain income level</li> </ul>	<ul style="list-style-type: none"> <li>Basic benefits package</li> </ul>	<ul style="list-style-type: none"> <li>Yes, but may be limited by HMO</li> <li>Expands use of managed care similar to HMO</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Caps on non-economic awards</li> <li>Periodic payments</li> <li>Reduces health care costs</li> <li>Eliminates double recovery</li> </ul>
<b>Health Care America</b> <i>American Association of Retired Persons' (AARP) proposal</i>	<ul style="list-style-type: none"> <li>Increases access</li> <li>No denials of preexisting conditions*</li> <li>Medicare coverage for all</li> <li>New emphasis on preventive care</li> <li>May result in rationing of care</li> <li>Increases bureaucracy</li> </ul>	<ul style="list-style-type: none"> <li>Similar to Medicare payments</li> <li>\$1,500 maximum for individual, \$3,000 for family</li> </ul>	<ul style="list-style-type: none"> <li>"Pay or play"*</li> </ul>	<ul style="list-style-type: none"> <li>3 percent income tax increase</li> <li>New taxes on alcohol and tobacco</li> <li>5 percent corporate surtax</li> <li>New 5 percent value added tax</li> </ul>	<ul style="list-style-type: none"> <li>Basic benefits package, plus long-term care at home, preventive medical care, catastrophic/nursing home care, and prescription drugs</li> </ul>	<ul style="list-style-type: none"> <li>Yes, for private physician</li> <li>Yes, for hospital</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Reform malpractice insurance to reduce health care costs</li> </ul>
<b>Canadian Health Care System</b>	<ul style="list-style-type: none"> <li>Access for all</li> <li>Single-payer provincial system</li> <li>Long waiting lines</li> <li>Rationed care</li> <li>Costs rising faster than in the U.S.</li> <li>Less high-tech equipment</li> </ul>	<ul style="list-style-type: none"> <li>Provincial or federal taxes up to 33 percent of personal income</li> </ul>	<ul style="list-style-type: none"> <li>No employer involvement</li> </ul>	<ul style="list-style-type: none"> <li>Federal tax and provincial tax started at 50-50 (federal-provincial)</li> <li>Now, 35 percent to 65 percent</li> <li>Makes up 30 percent of provincial budget</li> </ul>	<ul style="list-style-type: none"> <li>Basic benefits package</li> </ul>	<ul style="list-style-type: none"> <li>Yes for private physician</li> <li>Yes, for hospital</li> </ul>	<ul style="list-style-type: none"> <li>Their judicial system includes no contingency fee for lawyers</li> <li>Trial by judge, not jury</li> <li>\$230,000 cap on awards</li> <li>Loser pays malpractice cost</li> </ul>

Note: Reform proposals are listed as of June 1, 1992.

Basic benefits package: Health care plan offering basic inpatient and outpatient services.

Typically, insurance pays 80 percent and the patient pays 20 percent after a variable deductible amount is paid.

Glossary of terms: *Community rating* — Health insurance premium based on the health status of a large group rather than an individual. *Job lock* — Patient is "locked into a job" with his/her current employer because preexisting conditions make him/her uninsurable elsewhere. *"Pay or Play"* — Proposal requiring employers to either pay a tax to support health insurance (pay) or provide health insurance for their employees (play). *Preexisting conditions* — A medical condition, such as cancer, heart disease or AIDS that prevents patients from obtaining new insurance cover-



# CASE in POINT

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin

## Case #1

**Presenting complaint and initial diagnosis** – A 51-year-old man who had been smoking for 35 years went to his family physician complaining of a nagging cough. The physician took chest x-rays, but the films were overexposed and poor quality. Although the doctor read them as normal, later interpretation of the lateral x-ray showed a 1 centimeter density in the lower lobe of the left lung. The physician diagnosed bronchitis and prescribed appropriate medications.

**The case in brief** – One year later, the patient returned to his doctor for a check-up, still complaining of the cough. The physician took another set of chest x-rays, which he again read as normal although the mass in the lower left lung lobe had increased to 3.5 centimeters. Nine months later, alarmed because he was coughing up blood, the patient went to another physician who ordered x-rays. A radiologist read these films and identified a 4 centimeter nodule in the afflicted left lung. During surgery, a malignancy was confirmed and the entire left lung removed.

**The resulting claim** – The patient sued the family physician for failure to diagnose lung cancer, leading to delay in treatment that shortened his life expectancy and rendered him completely disabled. He also alleged that the family physician should have retaken the first set of chest films, and that he should have diagnosed the lesion when he took a second set of x-rays a year later.

**The outcome of the claim** – Although the family physician argued that the patient's long history of smoking contributed to his illness, the case was settled for almost \$600,000.

## Case #2

**Presenting complaint and initial diagnosis** – A 61-year-old woman went to a hospital for minor surgery. A preoperative chest x-ray suggested the presence of a density in the upper apex of the right lung.

**The case in brief** – The reviewing radiologist reported the finding to the treating physician and prepared a report recommending a follow-up x-ray in one month. However, the treating physician never read the x-ray report and never told the patient about the suspected lesion. Several

months later, the woman went to her family physician for a check-up. Another chest x-ray was taken in the office, which again revealed a density in the upper right lung. But this doctor also failed to note or to report the finding to the patient. A few months later, the patient moved to another state. When she suddenly began losing weight, she went to another physician who took a chest x-ray that indicated possible lung cancer. A thoracotomy confirmed adenocarcinoma of the lung with metastasis to two hilar nodes.

**The resulting claim** – The woman sued the two physicians who originally treated her, alleging that delay in diagnosing her lung cancer had reduced her chances of survival to 10 percent to 15 percent from 50 percent.

**The outcome of the claim** – The physicians settled for \$175,000.

## Case #3

**Presenting complaint and initial diagnosis** – A 41-year-old man went to his regular physician complaining of pain between his shoulder blades that worsened when he breathed deeply. The physician suspected degenerative disk disease and sent him for spinal x-rays.

**The case in brief** – A radiologist who read the film prepared a report saying the spine was normal, but that the patient appeared to have an 8 centimeter by 4 centimeter lung tumor. However, the radiologist did not orally communicate his findings to the treating physician, who looked at the x-rays and concluded that degenerative disk disease was present. He did not, however, see the lung tumor. Nor did the treating physician obtain the radiologist's written report, even though he saw the patient twice in the next two months. Five

months later, the man consulted an orthopedic surgeon who confirmed the radiologist's finding of a lung tumor, which by now had tripled in size and was inoperable. The patient died.

**The resulting claim** – The patient's family sued the treating physician for failure to diagnose lung cancer. The radiologist also was named for failure to communicate his findings to the treating physician in a timely fashion, contributing to the diagnostic delay.

**The outcome of the claim** – The case was settled for \$500,000.

**The points these cases make** – Pulmonologist James V. Vest, M.D., of Belleville, says that cases involving failure or delay in diagnosing lung cancer can be tragic and costly. He cites a 1992 study by the Physician Insurers Association of America that showed such claims are among the most expensive. The average indemnity payment is \$172,271, a figure that rises to \$254,422 when lung cancer is diagnosed in an advanced stage of metastasis.

Unfortunately, cases like the three summarized above are not uncommon, says Dr. Vest. "A classic example is one in which a doctor orders a chest x-ray of a patient who smokes, but that film is not accurately interpreted and a possible malignancy is not seen."

He suggests that chest x-rays be interpreted by a radiologist and an official report be placed in the chart.

A baseline chest film is also helpful when a suspicion exists about something a physician sees on a new x-ray, Dr. Vest says. "If something shows up on a new x-ray that wasn't there previously, it must be considered a malignancy until proven otherwise."

The recent PIAA lung cancer study notes that radiologists and other physicians performing or reviewing

chest x-rays "must be sensitive to subtle changes when comparing prior films to current ones." Dr. Vest agrees, stressing that this is particularly true if a patient is a smoker over the age of 35, is hoarse, and is coughing or losing weight.

When a physician finds something suggesting lung cancer on a chest x-ray, Dr. Vest advises seeking a consult. "A pulmonologist or thoracic surgeon should evaluate such a patient. Even though pulmonology is my specialty, when I have a question, I get second and third opinions. It's just good medicine."

Dr. Vest adds that communication slipups – instances in which a physician orders but does not obtain or see a chest x-ray report, or in which a doctor does not convey his findings to another – "happen every day," but can be prevented. He suggests that every office have a checking system assuring test results are obtained, findings relayed to patients, information properly recorded in the patient's chart, and any abnormal findings diligently followed up.

Lung cancer can be missed or misdiagnosed because it often has no initial symptoms, the pulmonologist says. "If a patient keeps coming back with a complaint, find out why. Have a high index of suspicion for lung cancer, especially with smokers, because tumors can be present even when chest x-rays appear normal," he emphasizes.

Sometimes a physician will recommend a follow-up x-ray within a specified time period, but a patient fails to comply. Dr. Vest advises sending such patients a registered letter repeating the recommendation and explaining some of the potential risks of failing to have the test. "Doing so not only shows you are concerned, but it provides written proof of your sincere efforts to encourage your patient to comply with your recommendation," Dr. Vest says. ▲

## Exchange Board Briefs

*The Illinois State Medical Inter-Insurance Exchange Board of Governors met June 5 at the Illinois State Medical Society Conference Complex in Chicago. Following are highlights of the meeting.*

### Exchange studies anesthesiology, surgery risk management issues

The Exchange has distributed "Exploring Liability Issues in Anesthesia," a booklet on risk management, to all anesthesiologists insured by the Exchange. The booklet was researched and written by a physician committee of Exchange anesthesiologists. The Exchange committee will continue its work by studying, with the American Society of Anesthesiologists Committee on Professional Liability, Exchange anesthesiology closed claims. Anesthesiologists are acknowledged pioneers in aggressive risk management research and publishing, with the result of significant risk reduction in the specialty for most physician malpractice insurers, including the Exchange. The Exchange Risk Management Committee is led by Henri S. Havdala, M.D.,

of Mt. Sinai Hospital Medical Center in Chicago.

A committee of surgeons insured by the Exchange, led by Alfred J. Clementi, M.D., has researched surgical liability issues and their findings will soon be published in a similar booklet to be distributed to all physicians insured with the Exchange who perform surgery.

Three Exchange plastic surgeons and two defense attorneys who represent Exchange physicians are studying liability issues surrounding breast implants. Their work will result in a booklet on legal and risk management concerns arising from the U.S. Food and Drug Administration investigations and recent media reports. The committee also plans educational presentations on the issue.

### Data Bank reporting procedures refined

The Exchange continues to study, refine and improve its procedures for reporting policyholders' claim losses to the National Practitioner Data Bank. Policyholders receive Exchange loss reports prior to their

submission to the Data Bank and are encouraged to participate in the preparation of the report to ensure its accuracy. Physicians are encouraged to respond promptly to Exchange Data Bank submission requests to reduce Data Bank inaccuracies and prevent paperwork hassle for the physician. The Exchange is required by federal law to report policyholders' losses to the Data Bank. The Exchange is well aware of the controversial nature of the Data Bank, and is seeking to make its required reports as palatable as possible for policyholders.

### Exchange to provide loss histories direct to physicians

The Exchange will now provide loss histories directly to a physician policyholder, rather than an inquiring third party, as a result of Exchange efforts to improve policyholder satisfaction. This gives the policyholder the opportunity to review loss history information before providing it to the requesting third party, such as a hospital, HMO or PPO. ▲



# State police cracking down on prescriptions for tinted car windows

by Tamara Strom

PRESCRIPTIONS FOR tinted auto windows may soon be an Rx for trouble for Illinois physicians. At the prompting of concerned legislators, the Illinois State Police is cautioning physicians to adhere to the provisions in a state law banning tinted car windows except in medically necessary cases.

"While the state police understand and support the need for physicians to write these prescriptions for some of their patients, it appears we are beginning to see the signs of wholesale distribution of these doctors' notes in some parts of the state," said Sgt. Carl Weitzel, a legislative liaison and public information officer for the state police. "This influx of questionable notes waters down the exemptions and threatens their existence completely."

At issue is an Illinois law prohibiting tinting or darkening of the front side windows and windshields of cars. Passed and revised several times in the 1980s, the law bans tinted glass for three reasons: to allow drivers to make eye contact with other drivers and see through their cars at all times of the day; to protect law enforcement officers from approaching a car they cannot see into; and to avoid the concealment of illegal activities, such as hostage situations, drug use and sexual assault.

*"We're looking for some old-fashioned cooperation from physicians. We want to be able to operate on a handshake, on a nod."*

Exemptions exist only for those drivers who have true sensitivity to light that tinted windows may ease. Weitzel cited patients with lupus as an example of drivers who may benefit from tinted windows. But he stressed that the law relies on a physician's judgment as to whether a patient has a certifying condition.

According to the legislation, waivers are possible for those individuals who have a "medical illness, ailment or disease" that creates a "specific and dire need to shield them from the rays of the sun," Weitzel said. "The danger for people who truly deserve the exemption is that if these abuses don't stop, [the legislature] could yank the exemptions. There are enough infuriated and influential legislators who will take away the exemptions."

The problem, he explained, is that in some Illinois communities young drivers in "racy" cars are being pulled over by state troopers because their cars have tinted windows. Many of these drivers have doctors' notes saying they need the windows because their eyes are sensitive to light. One state trooper in Decatur stopped more than a half-dozen drivers with tinted windows - all were in their twenties or thirties, all had a doctor's note saying their eyes were sensitive to light, and all were

driving cars that "just happen to look better with tinted windows," such as Z28s, BMWs and Camaros, Weitzel noted.

"I'm not a physician, so I can't say who is truly sensitive to light," Weitzel said. "The point is some people need [the exemptions]. It seems to me some of these people could be wearing sunglasses."

Weitzel said the problem has gotten so bad in some areas that the next step could be subpoenaing the physicians who write these notes to appear in court with the driver to



certify the medical need for the waiver. "Imagine the lost time and energy," he said. "It would be a half-day wasted in all but the most efficient of counties. And imagine a physician in Cook County having to come down to Sangamon County to testify in court; drivers don't always get pulled over in the counties where they live."

Wanting to avoid the "crime" of heaping more "suffocating bureaucracies" on physicians, Weitzel said the police and other interested parties are striving to avoid the worst-case scenarios of subpoenaing physi-

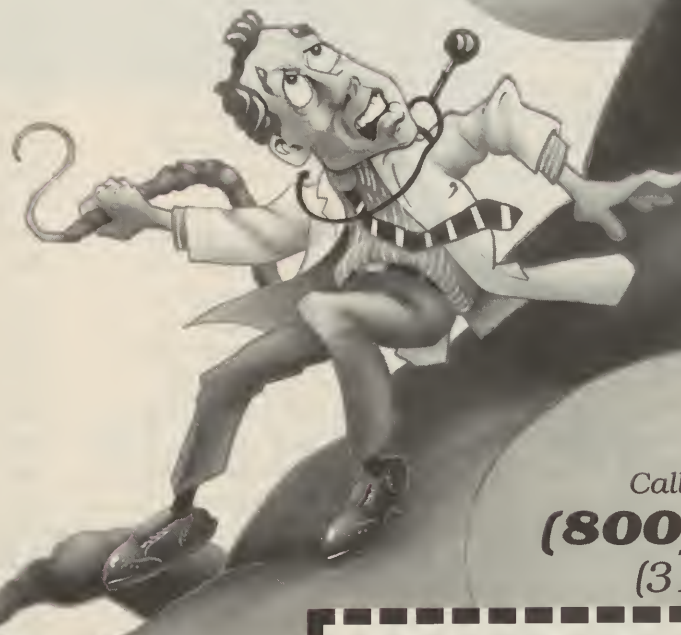
cians and yanking the exemptions completely. "This is being done in the spirit of good will, but the tide is turning," he noted, adding the state police would rather take administrative action to correct the abuses than rely on legislative remedies. "That's why we're looking for some old-fashioned cooperation from physicians. We want to be able to operate on a handshake, on a nod."

So if patients come into doctors' offices asking for a prescription for tinted windows simply because the sunlight hurts their eyes, Weitzel said physicians should consider the request carefully. "All we're asking is that the doctor say, 'How about a pair of sunglasses, son?'" ▲

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# Choosing a waste hauler doesn't need to be a dirty job

by Tamara Strom

CHOOSING A REPUTABLE medical waste hauler, or deciding to do it yourself, is proving a formidable challenge for many Illinois physicians. It doesn't have to be.

Exemptions for offices that generate less than 50 pounds of waste a month – the category into which most physicians fall – make it easier to comply with Illinois' new Potentially Infectious Medical Waste Act. But the exemptions do not alleviate doctors' responsibilities to ensure that any waste from their offices is hauled, disposed of and destroyed properly.

The first decision to make is whether you want to haul it yourself. "Unless physicians are in a large group practice or practicing in a large building, they probably won't have the means to treat the waste themselves," said Nelson "Sig" Slavik, president of Environmental Health Management Systems, a national consulting and managerial firm helping hospitals and physicians with hazardous materials compliance. "If they don't have the resources, most physicians will opt to route their waste through an outside contract of some sort."

Legally, small physician generators can haul their waste, including sharps, themselves to the hospital where they practice and have it disposed of there. But, Slavik said, many hospitals are shying away from accepting waste from their medical staff members because they "don't want to incur the potential liability or bother with a lot of different physicians" bringing in waste.

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*"Waste disposal is probably not the highest priority on physicians' minds, but they should at least think about it particularly because of the liability aspect."*

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Physicians in Chicago should ensure they adhere to the provisions of the city's medical waste ordinance, which includes daily hauling limits. For example, physicians who choose to haul their own waste can transport no more than six pounds a day to maintain their small generator exemptions. For more information about the city law, contact the Chicago Medical Society.

Because medical waste regulation is "a whole new area" for physicians, Slavik admits finding a reputable waste hauler may seem confusing. But, he advises physicians to take their time and thoroughly check out the firms they are considering. (See checklist at right.)

"It's not that difficult, but some physicians really struggle with it," Slavik said. "Physicians need to recognize that there is a liability attached to the waste they generate. Waste disposal is probably not the highest priority on physicians' minds, but they should at least think about it particularly because of the

liability aspect."

Slavik suggests physicians start by checking out potential waste haulers with their local hospital by asking which firm the facility uses and if it meets suggested standards. "Let the hospital do the background work," he said. "Physicians can take advantage of [the fact that hospitals already have haulers] and not try to reinvent the wheel. It's just a simple phone call to the hospital's purchasing agent or safety officer."

Physicians should use a checklist similar to the one below in choosing a hauler, said Ed Juracek, president of Compliance Resources Inc., a consulting firm for hospitals and the medical industry. Juracek also is chairman of Medical Compliance Inc., a potentially infectious medical waste trucking firm, and served as a member of the governor's Medical

Waste Tracking Study Group, which made recommendations for the law.

Juracek recommends physicians maintain complete documentation that tracks the waste's progress toward destruction to show authorities that it was disposed of legally. Doctors should keep these records for three years, including a copy of the manifest for each waste shipment that leaves their office. This log should be specific and include the doctor's name; it should not be a copy of a manifest for a "mass transport or destruction" load, he said.

Price is another area of concern for physicians. "Doctors are in a bad position [to negotiate good rates with haulers] because they're such small generators," Juracek said. "Many generate only four to 30 pounds a month, whereas a hospital can generate up to 10,000 pounds a

day, depending on its size, and can therefore demand lower prices." But Juracek cautioned physicians not to focus too heavily on price. Making sure the hauler is reputable is more important because the chain of liability goes back to the waste producer.

Slavik recommends physicians take control of the negotiating process. "The generator never feels as if he's in the driver's seat in this process and often feels manipulated," he said. "But you can manipulate back if you know the right questions to ask. Many haulers try to give boilerplate and generic contracts without specifics. Physicians should demand specific contract clauses even if the haulers are reluctant. Or choose another hauler who will include these provisions. Tell the hauler, 'You'll modify your contract if you want me as a client.' " ▲



## Use this checklist to assure compliance with state waste disposal regulations

- ✓ 1. Make sure the hauler has a permit with the Illinois Environmental Protection Agency to haul and dispose of potentially infectious medical waste (PIMW). Haulers should willingly provide a copy of their permit. To verify a hauler's credentials, you can call the IEPA's Land Pollution Control Division at (217) 524-3300. The IEPA also can tell you if the trucking company has any outstanding citations, and verify that the hauler is PIMW-permitted and has paid its quarterly licensing fee.
- ✓ 2. Ask for documentation of the company's certificate of insurance. The minimum coverage a hauler should carry is \$1 million in sudden and accidental insurance per incident. The hauler should provide a certificate that includes the name of the insurance company and specifies the amount of coverage. If you have any doubts, verify the coverage with the insurance company. Some larger waste hauling firms are self-insured. In this case, obtain a signed letter from the company president or other official confirming that a self-insurance program for the firm exists.
- ✓ 3. Be demanding when negotiating a contract. Do not sign a contract that does not include answers to the following questions, or provide appropriate detailed information:
  - Who is going to be handling the waste? All haulers should be listed, and all the different disposal companies should be listed as well.
  - Does the company have permits in all the states in which it hauls and handles waste?
  - If contractors or subcontractors will be used other than those listed on the contract, the company should guarantee it will contact you first so you can obtain appropriate documentation. As the waste generator, you may be held ultimately – and financially – responsible if something goes wrong at any point during the hauling, disposal or destruction process.

- The type of treatment and/or type of destruction to be used. Whether the waste will be incinerated, autoclaved or whatever, the process should be delineated.
- Where is the waste going?

That is, what is the "terminal location" where this material will be treated or disposed? If the waste will travel through Indiana for disposal in Ohio, the contract must list *both* states. The *final* destination must be listed.

- A provision for proof of destruction. As the generator, you need a signed, dated and completed document from the waste's ultimate disposal site certifying the waste has, in fact, been destroyed. This can be a separate document or maybe part of the manifest transport tracking system. Without this documentation, you cannot prove that your waste was ever destroyed.

- Ask for a 30- or 60-day escape clause, so that if you are unhappy with the company's service, or they do not provide all the services they claim, you are not stuck in an unsatisfactory relationship.

- Don't sign a contract for longer than one year. Although some companies are pushing three-to-five year contracts, try the company and its service for a year before you sign on long term.

- ✓ 4. Don't pay for the hauling until you receive the certificate of destruction. Make sure the hauler gives you a certificate of destruction and proper disposal – not a certificate of treatment – from the receiving site, signed by a representative at the site. Some companies are using a rubber-stamp certificate. This is not acceptable; this certificate is the only verification you have that the waste was destroyed properly. Rubber stamps with no signature provide no protection from liability.

- ✓ 5. Shop around. Price should be your last consideration in choosing a hauler. If the above provisions are not met, no amount of discount pricing will be worth it. Do not look for the cheapest rate; chances are you'll get what you pay for. You do not have to choose the biggest firm either; several smaller – and capable – companies are cropping up that can do a respectable job without charging as much as larger companies. Try to find a firm that disposes of the waste in Illinois to avoid double fees imposed by other states that receive your waste. This may be difficult because currently 95 percent of all medical waste hauled out of Chicago leaves the state. ▲



# Rules for Illinois waste law moving forward

by Tamara Strom

RULES TO REGULATE transporting, treating, storing and disposing of medical waste in Illinois are ready for public comment. Promulgated by the state Environmental Protection Agency to implement the Illinois Potentially Infectious Medical Waste Act, the rules reflect the input of organized medicine. If approved by the state Pollution Control Board, the rules will go into effect Jan. 1, 1993. The law itself became effective Jan. 1 of this year and physicians already are bound to comply with general provisions of the legislation.

Illinois State Medical Society representatives were involved in the rule-making process and will continue to work to ensure that provisions fair to physicians in the proposed rules remain intact. The rules include exemptions for small waste generators — those who dispose of less than 50 pounds a month. Many Illinois physicians fall into this category.

The exemptions allow physicians to transport their own medical waste to a proper treatment and disposal site without obtaining a state waste hauling permit or paying a licensing fee. In some instances, this exemption also saves physicians the cost of hiring a waste hauling firm, although many physicians choose this option for convenience. (See related story on previous page.)

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*"We're concerned these proposals would expand the definition of medical waste ... and have terrible consequences on trying to hold down health care costs."*

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Whether physicians choose to haul office waste themselves or hire someone to do it for them, they must adhere to specific packaging requirements spelled out in the proposed rules. Waste containers must be rigid, leak-resistant and impervious to moisture. In addition, all cartons must be marked in indelible ink with the physician's name, address and 24-hour phone number, if available. Sharps must be packaged separately from other medical waste; all cartons containing sharps must be labeled as such and carry the international biohazard symbol. Required markings must appear on two sides of the packaging and be visible from at least five feet away.

The rules allow hospitals to accept for treatment medical waste generated and transported to the facility by members of their medical staff. When transporting potentially infectious medical waste, haulers (including physicians, if they are transporting their own) must transport the waste in "enclosed compartments of vehicles that are secured against public access when unattended," according to the proposed rules. Therefore, it is advisable for physi-

cians to lock all cartons of waste and sharps containers in a car trunk during transport, to avoid tampering or theft.

## **Movement afoot for federal regulation**

While Illinois is in the process of implementing medical waste regulations, proposals by several lawmakers on Capitol Hill would pre-empt state laws with a sweeping federal medical waste law. Currently, 44 states have enacted medical waste legislation of some type. The waste hauling industry, with a large financial stake in expanded regulation and hauling requirements, is pushing hard for federal action.

Any federal legislation, however,

would likely be significantly more restrictive than Illinois' law, with its small generator exemptions.

Three bills — one in the House of Representatives and two in the Senate — were introduced this session that include medical waste provisions as part of Congress' reauthorization of the Resource Conservation and Recovery Act, according to the American Medical Association. "The AMA is lobbying strongly against all attempts to put in medical waste provisions," said Mike Zarski, AMA legislative counsel.

One Senate bill has already advanced out of committee; it includes "the least objectionable definition of medical waste," Zarski said. Bill lan-

guage defers to the U.S. EPA to grant exemptions for small waste generators, he said. Although that bill is the "lesser of three evils," Zarski said, "We're concerned these proposals would expand the definition of medical waste so that the volume of material coming out of doctors' offices and hospitals would be so great that it would dramatically increase costs and have terrible consequences on trying to hold down health care costs."

Federal legislation at this point is premature, the AMA contends, because the final report from a two-year demonstration project under the Medical Waste Tracking Act of 1988 has not yet been submitted to Congress. An interim report on the project did not recommend federal regulations. Illinois opted out of the pilot program. ▲



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# ISMS Council and Committee Appointments

*Jere E. Freidheim, M.D., chair of the Illinois State Medical Society's Board of Trustees, announced the following ISMS council and committee appointments. The appointments, ratified by the Board at its June 6 meeting, are for one-year terms. Nominations for council and committee appointments are submitted by officers and trustees, county medical societies, specialty societies and individual physicians. ISMS members are encouraged to save this page for future reference and contact council and committee volunteers to share comments, suggestions and ideas.*

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Computer specialist is June Employee of the Month

by Kevin O'Brien

JUNE'S EMPLOYEE of the Month, Steve Vittum, makes comprehensible that which to many is a mystery – the world of computers, said Diana R. Role, vice president of Management and Computer Services, when presenting the award June 1. The award is presented monthly to an employee of the Illinois State Medical Society or Illinois State Medical Insurance Services.

"It's a real joy to be able to help out and do what we can to make your jobs a little bit easier."

"In the seven years Steve has been with us, he has introduced several new computer programs," said Role. "These new programs ... have shown

innovation and creativity, allowing us to become more service-oriented and enabling all of us to maximize our ability to serve physicians and fellow employees alike. And he has done so as an enthusiastic member of a team."

Role also cited Vittum's friendly and helpful attitude. "Steve's skill and knowledge, coupled with his ability to make his very technical world more accessible to the rest of us, make him an ideal candidate for our Employee of the Month award," she said.

Steve joined ISMIS as a project manager in March 1985, and was promoted to director of computer services in March 1991. He received a plaque and a check for \$200 during the brief award ceremony at ISMS headquarters in Chicago. His name will also be added to a special plaque in the ISMS reception area listing all award winners.

"It's a real joy to be able to help out and do what we can to make your jobs a little bit easier," Vittum told his fellow employees. "I hope

that you'll continue to feel free to come to our division when you need something."

Vittum also thanked his colleagues in the Management and Computer Services Division for their "support, talent, energy, ambition," without which "this award would not have been possible under any conditions."

All permanent, full-time ISMS/IS-MIS employees – except those at senior management level – are eligible for the Employee of the Month award. Physicians who wish to nominate a staff member for the award should call the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ▲



ISMIS Director of Computer Services Steve Vittum was named June Employee of the Month.

Avoid hassles: Update addresses now

ALTHOUGH THE final deadline for Illinois medical license renewal is still more than a year away, the Illinois Department of Professional Regulation is recommending physicians act now if their address has changed since July 1990. The department requests that physicians who have moved since the last license renewal date update their addresses before March 1993. Current licenses expire July 31, 1993. Address changes may be submitted in writing only; no changes will be

accepted over the phone. *Illinois Medicine* has provided the form below for physicians who need to update their department files. Physicians wishing to change their address on an Illinois controlled substance license should contact IDPR regarding specific procedures to follow. For more information, contact the Illinois Department of Professional Regulation, Licensure Maintenance Unit, 320 W. Washington St., 3rd Floor, Springfield, IL 62786, or call (217) 782-0458. ▲

Physician Address Change Notification Form

Please type or print legibly

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036- \_\_\_\_\_

Registrant's name: \_\_\_\_\_

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(22) \_\_\_\_\_

(23) \_\_\_\_\_

(24) \_\_\_\_\_

(25) \_\_\_\_\_

(05) City: \_\_\_\_\_

(06) State: \_\_\_\_\_

(07) ZIP Code: \_\_\_\_\_

(08) County: \_\_\_\_\_

Signature of registrant: \_\_\_\_\_

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

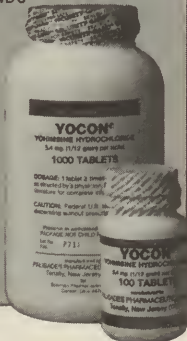
**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

- References:**
1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
  2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
  3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
  4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## Gallup survey

(continued from page 1)

asked what dollar limit should be set on pain and suffering awards, 77 percent said the cap should be \$1 million or less; 23 percent said a \$100,000 cap was reasonable.

*"We've worked hard to educate people about the effects of frivolous malpractice suits and outrageous jury awards on health costs. ... We see that our educational efforts are paying off."*

"We're really pleased with the increased level of understanding among the general public about medical malpractice issues," Dr. Freidheim said. "We've worked hard to educate people about the effects of frivolous malpractice suits and outrageous jury awards on health costs. From these results we see that our educational efforts are paying off."

### Less than \$1,000 a year

While respondents said reform of the nation's health care system is needed, they were split on which system would be the best to adopt.

Forty-four percent favor a government-financed national health plan; 33 percent support mandated employer coverage; and 21 percent advocate individuals buying their own health insurance, with poor and low-income citizens receiving tax credits and vouchers to obtain insurance.

Sixty percent said they would pay increased taxes to fund a national health care system, but 52 percent said they would not be willing to pay more than \$1,000 in additional taxes for that care. Respondents also seemed to favor paying more money directly to health care providers instead of paying the government through increased taxes: 56 percent said they would absorb more out-of-pocket expenses to reimburse physicians and hospitals directly, compared to 40 percent who would rather pay higher taxes and have the government in charge of organizing and delivering health care.

Respondents also favored the current fee-for-service system that protects patients' freedom of choice in selecting a physician. Eighty-two percent would pay more to choose their own doctor, while 16 percent would rather pay less and not choose.

In addition to the positive news on tort reform from the survey, the poll also elicited some negative responses about physicians. Fifty-eight percent of respondents said doctors "don't care about their patients as much as they used to," and only 37 percent believe doctors' fees are reasonable.

"A subtle perception exists that physicians aren't as caring as they used to be and that they are greedy," Dr. Freidheim said. "Doctors have a

## Illinoisans' attitudes toward rising health care costs

**There has been a great deal of talk recently about the rising costs of health care. What do you think are the major reasons for the increasing cost of health care?\***

(Multiple responses were allowed.)



\*400 Illinoisans were asked this question in a March 1992 Gallup/AMA public opinion survey. Source: Illinois State Medical Society.

public image problem. To correct these misperceptions, individual physicians must take an active role in educating their patients about where health care dollars go; it's certainly not all going directly into the doctors' pockets."

Dr. Freidheim also noted that physicians can use health care consumers' greater recognition of health problems related to drug abuse, AIDS and teen pregnancy, as reported in the survey, as a jumping-

off point to help patients assume more responsibility for their own health care.

"Physicians need to seek more personal interaction with their patients to discuss prevention and education," he said. In fact, 74 percent of those surveyed said they discussed preventive medicine with their physicians. "If we could get our patients to take our prevention messages to heart, we could make inroads toward curbing unnecessary disease." ▲

## Board Briefs

The Illinois State Medical Society Board of Trustees met June 6 at the ISMS Conference Complex in Chicago. Following are highlights of the board's actions.

### ISMS will file amicus curiae brief for jailed physician

ISMS will file a "friend of the court" brief at the appellate level on behalf of James V. Vest, M.D., a St. Clair County physician who was jailed for declining to provide detailed information to a plaintiff's attorney about care rendered by another physician. The plaintiff's attorney deposed Dr. Vest, the treating physician, before a suit was filed and attempted to gather information he could later use to satisfy the certificate of merit requirement in medical malpractice cases. Dr. Vest was jailed along with two attorneys representing him. The certificate of merit requirement for filing medical malpractice cases was recently upheld in the Illinois Supreme Court.

### ISMS continues fight against physician involvement in lethal injection

ISMS agreed to support an amendment to current law to remove the anonymity protections for physicians who may involve themselves in an execution by lethal injection, but agreed that the attempt to delete the current requirement of physician participation in executions should be ISMS' highest legislative priority. In keeping with 1991 House of Delegates policy, ISMS caused H.B. 1307, which removes physicians from participation, to be introduced. Subsequent to the deadline for introduction of bills, the 1992 House of De-

legates called on ISMS to exempt physicians from the anonymity provisions provided to all witnesses and other persons involved in the process. Considerable opposition is expected from many legislators and the Illinois Department of Corrections against removing the anonymity provisions.

### ISMS Washington presence accomplishes PRO representation

ISMS' Washington presence program is working to successfully address Illinois physicians' representation concerns with the Illinois PRO contractor. ISMS leaders recently travelled to Washington, D.C., and met with senior officials of the U.S. Health Care Financing Administration to request appropriate representation on the Crescent Counties Foundation for Medical Care leadership bodies. HCFA officials agreed to help press for CCFMC representation by the Chicago Medical Society and downstate counties to have representation. ISMS has also continued its dialogue with local HCFA officials on the representation issues, as well as other issues of concern to physicians.

ISMS has also adopted 15 PRO criteria for the Society to use in screening potential PRO contractors. The criteria center on fairness, representation, responsiveness, communication and cooperation between physicians and the PRO. ISMS has requested that HCFA prevail upon CCFMC leadership to open the doors for meaningful communication between organized medicine and the PRO.

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# LifeSource kicks off summer blood collection campaign

by Anna Brown

LIFESOURCE Blood Services, Illinois' largest blood center, will attempt to avert an annual summer blood shortage with a push to recruit 61,200 donors over the next four months. The campaign "Live it Up! Donate Blood!" which began May 18 and will continue through Oct. 12, includes six to eight local blood drives a day, and features special events aimed at attracting new donors.

"We don't want to have to go to the media with a crisis this year," said LifeSource spokesman Linda Dillman, noting that summer is traditionally a difficult time to obtain blood. Prime donor sources, such as high schools and colleges, suspend blood collection during those months. "We need to collect 600 units a day to meet patients' needs on an average day."

LifeSource serves 55 hospitals in northern Illinois. To supply these hospitals, the center must import 21 percent of its blood from outside the Chicago area.

"We have to depend on other parts of the state, and even other states," Dillman said. "But when we're low in Chicago, they're low elsewhere too. That's why it's important to reduce dependence on imported blood."

Holidays and weekends are espe-



cially difficult times to collect blood, Dillman said. LifeSource is intensifying efforts during these times with events such as "Sensational Sunday" in July, and "Be a Summer Sport" week in August. During the July event, donors will receive raffle tickets for a cruise on the Odyssey, which departs from Chicago's Navy

Pier and features gourmet dining. Donors participating in "Be a Summer Sport" week will receive two tickets to Arlington International Racecourse. Other raffle prizes will include a weekend for two at Chicago's Bismarck Hotel and tickets to Chicago Cubs games.

"Anyone who comes to one of the 14 donor centers will be eligible for a prize during these events," Dillman said, noting even those who are found to be medically ineligible to donate blood may participate.

## Corporate blood center a first

LifeSource recently opened a new blood facility in the Deerfield headquarters of the health care conglomerate Baxter International.

Dillman said the blood center, which opened Feb. 18 exclusively for Baxter employees and their families to donate blood, is the first of its kind in the nation. Blood from the center becomes part of LifeSource's supply for use throughout northern Illinois.

"Our hope is that Baxter will inspire other companies to open centers," she said. "So far the center has been most successful at collecting whole blood, but they also collect platelets, which takes about an hour and a half."

The Baxter facility is open three days a week and employees are allowed to donate blood on company time. ▲

## ISMS supports liability, licensure provisions in UR

ISMS board members reaffirmed their strong commitment to regulating utilization review that would include explicit liability responsibility on reviewing entities for patient injury resulting from UR and Illinois licensure for physician reviewers. ISMS-backed legislation is stalled in committee because business, insurance and UR organizations adamantly oppose including the liability requirement.

## ISMS supports fairness in self-referral legislation

ISMS adopted the American Medical Association's Council on Ethical and Judicial Affairs Report C (I-91), which states it is unethical for a physician to refer a patient to a health care facility outside his or her office practice in which he or she has a financial investment and in which he or she does not directly provide care. The ISMS board strongly agrees, however, that legislation regulating physician self-referral should allow doctors adequate time to meet the new referral requirements, and should specify a process for allowing exceptions.

## ISMS opposes intrusive IDPA psychiatric inpatient review

ISMS has worked with the Illinois Department of Public Aid to derail a proposal that would have allowed psychiatric UR to interfere in the doctor-patient relationship by reducing the authority and responsibility

(continued on page 16)



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## OSHA

(continued from page 2)

postexposure evaluation and follow-up; the treating health care worker's opinion; and a copy of all supplemental information given to the treating health care worker. Physician-employers must maintain these confidential medical files for 30 years after the employee stops working.

Physician-employers also are responsible for keeping records of the training employees receive. The files should list names and job titles of workers, training dates, a summary of the training provided, and the names and qualifications of the educators.

All records must be complete and easily accessible to both employees and OSHA inspectors, the regulations state. Failure to comply with any or all of the provisions listed in the bloodborne pathogen standard could result in stiff monetary penalties – up to \$70,000 for each willful or repeated violation and \$7,000 for other individual violations. Certain violations could result in \$7,000-a-day fines if not immediately corrected on detection by OSHA investigators. Although most of these are maximum fines, minimum penalties for willful non-compliance are \$5,000 per occurrence.

### Employee hepatitis B vaccines

The next – and last – OSHA deadline is July 6, by which time doctor-employers must be providing all protective clothing and equipment called for under the statute. In addition,

the hepatitis B vaccination process must at least be under way for all employees.

Because the three-injection vaccine regimen takes six months to complete, OSHA requires only the series be started by the July 6 deadline. While OSHA cannot mandate that employees receive the vaccine, the agency does require workers who do not wish to be vaccinated to sign a waiver indicating their desire. Physician-employers must retain this document in the worker's medical records. Employees may change their minds at any time and elect to receive the vaccination, OSHA says; physicians would then be mandated to provide the vaccination.

Physicians should already be in compliance with several other requirements. For example, explicit exposure control plans should be in place in all physician offices where employees come in contact with blood or other body fluids. These plans should outline the risks of exposure for each employee, explain how employees will be protected from these exposures and detail what training the workers will receive. This requirement went into effect May 5.

For help in complying with the OSHA statute, the American Medical Association has produced a bloodborne pathogen compliance kit. The package includes an instructional video, an administrator's guide and a training manual, and costs \$150 for AMA members. The video alone is \$75. To order, call (800) 933-4AMT. ▲

## Oregon plan

(continued from page 1)

thony Medical Center of Rockford, attracted 140 physicians.

To implement the plan, the federal government has to permit the state to make two alterations to their Medicaid payment services. "We are asking to be able to include non-categorical groups," Dr. Kitzhaber said in an exclusive interview following his address. "We want to include poor men and women without children; they don't [currently] fall into Medicaid categories."

"Secondly, we're changing the benefit package. There's a series of federally mandated coverages you have to provide to get matching dollars and we're changing that to our prioritization process."

The coverage list prioritizes health care on the basis of effective benefit, based on clinical effectiveness and social value. It was prepared by a governor-appointed Oregon Health Services Commission a year ago. The 11-member commission included five primary care physicians, a public health nurse, a social worker and four consumers. After an actuary determined the cost of each of the 709 services, the public provided input in a series of public hearings and town hall meetings.

The legislature designated \$33 million from general revenue income taxes to fund the first 587 items on the list. "If we're granted the federal waiver, that money will be matched about 2-to-1 by the federal government," said Dr. Kitzhaber.

"We're trying to provide universal access to a basic level of health care to all Oregonians and to define what that constitutes," he said.

Physicians and hospitals who will provide care under the plan are already "getting themselves organized in anticipation," he said. The program will begin as a five-year demonstration project, and the initial phase

would run until the end of Oregon's fiscal year, July 1, 1993. The legislature, which meets every two years, would review it on alternate years, revising the priority list and refunding the program. A provision allows midcourse alterations to reflect advances in technology.

### Broad support for plan

Dr. Kitzhaber said the plan has "broad support" from providers, insurers, consumers and payers. The list includes the Oregon Medical Association, the Oregon Hospital Association, Blue Cross and Blue Shield of Oregon, the AFL-CIO, Associated Oregon Industries and a variety of consumer groups, such as Healthy Mothers Healthy Babies. He said "the legal profession is being fairly supportive," and political support is bipartisan.

Roman Catholic bishops oppose the plan because "it's rationing health care," Dr. Kitzhaber acknowledged. "But all Catholic hospitals and providers are strongly supportive."

Abortion is not included in the benefit package, he said. Oregon pays for abortions for low-income women as a separate item, so it is not a part of the waiver request.

A collateral program, the plan's version of a "pay or play" system for employers, is scheduled to begin in 1995. Employers will be required to provide the basic health care package to employees, either by purchasing a policy or paying into a state fund to provide the coverage.

If the waiver request fails to receive federal approval, the next legislature would address federal concerns and reapply, he said. "In the meantime, 120,000 citizens below the poverty level and another 300,000 above the federal poverty level wouldn't get access. So the federal government would be saying, 'We would rather that a half million Oregonians continue to be without health care.'" ▲

## Board Briefs

(continued from page 15)

of the attending psychiatrist in inpatient facilities.

### Brochure planned to address rural health concerns

ISMS will publish and distribute a brochure to help rural communities and physicians address access problems. "Prescription for Rural Health: Community Action" will be distributed widely throughout Illinois. It includes practical suggestions for communities about how to get organized; how to conduct physician recruitment; and national, state and local resources available to assist rural communities in these efforts.

### ISMS recognizes Chicago Medical Society patient education efforts

ISMS will continue its emphasis on fighting single-payer, government-run health care legislation at the state level, and agreed that the Chicago Medical Society's patient education efforts, publishing and distributing a brochure on various national health care proposals, is to be commended. ISMS will continue its efforts to provide information to physicians and patients for their use

in making informed decisions about health care reform through the development of health care reform materials for physicians to distribute to patients.

Officers, trustees and councils have joined together in an all-out effort to fight legislative proposals that would create a state-run, taxpayer-funded, Canadian-style health care system in Illinois. ISMS leadership has met with editorial boards throughout the state to talk to editors about the disastrous effects such a system would have on patients. ISMS has also testified before legislative committees and ISMS members have contacted legislators individually on this issue. ▲



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accommodations being offered or would result in an undue burden, i.e., significant difficulty or expense.”

“In [the above] case, it wasn’t handled very well,” says Lei Ann Marshall-Cohen, legal consultant to the National Center for Access Unlimited, a consulting firm specializing in ADA compliance issues. “The patient in that example should have made the request to the physician. In other words, it shouldn’t come after the fact.” She suggests that physicians who know a prospective patient is disabled should make the first move. “For example, you could do it one of two ways. You could say [to the patient] ‘Please let my staff know if you need a sign language interpreter, and we’ll make that arrangement. Or, alternatively, you can bring your own and we’ll pay for that.’”

The law says that each place of public accommodation has to determine what is reasonable for that business, Marshall-Cohen says. “Generally speaking, in most medical practices, I think what would probably be a relatively occasional request

for the services of sign language interpreter – say, \$35, and you have six patients a year making the request – that couple hundred dollars isn’t going to be viewed as ... unreasonable.”

Since similar arrangements need to be made for visually impaired patients, does it mean that a physician needs to provide printed materials in braille? “The answer would be no, there are lots of other ways,” says Marshall-Cohen.

“Let’s assume a new patient comes in and has to fill out a form,” says Earl B. Slavitt, an attorney with Katten, Muchin & Zavis. “And let’s assume the patient is blind. The physician has to establish a policy for not discriminating against that person by either having a nurse ask the questions and write down the answers, or by providing some other way for the patient to provide the information.”

Title III also prohibits physicians from retaining other policies, not just in communications, that discriminate against disabled people.

“For instance, let’s assume a doctor doesn’t want to see a patient with cerebral palsy because he doesn’t want to have somebody sitting in a

waiting room twitching. ... It may be an unstated policy, but it gives rise to a cause of action,” says Slavitt.

Or a physician “might logically have a rule that no one could bring in a pet,” says Marshall-Cohen, “but if you had a patient who is blind and has a Seeing Eye dog, you would modify that rule in order to accommodate that individual.”

Slavitt adds that the law exempts physicians from treating people whose illnesses are outside their specialty. In such cases, the physician must still refer the patient to a physician who can treat them.

Both experts agree the best thing physicians can do to comply is to consider seriously what communication and other obstacles exist, what policies should be altered, and make provisions for addressing them.

“It [compliance] really requires that physicians think about the situations ahead of time, so that they’ve got some sort of protocol in place. And that’ll make everything happen much more smoothly,” says Marshall-Cohen. ▲

– Next: ADA compliance as it applies to disabled employees.

## Types of auxiliary aids and services

THE REGULATIONS for Title III of the Americans with Disabilities Act list types of auxiliary aids and services that physicians may employ to ensure access to their professional services for patients, or accommodations for their disabled employees:

*Qualified interpreters or readers, note takers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices and systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDDs), videotext displays, taped texts, audio recordings, materials in braille, large-print materials, or other effective materials that ensure communication.* ▲

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## Universal health opponents claim victory

*Supporters of a  
Canadian model failed  
in several attempts to  
advance legislation this  
session*

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# Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JULY 17 1992



*Highlights of  
the General  
Assembly  
spring session*

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## Legislators end session trying to plug holes in state budget

**BUDGET:** Negotiations on funding Illinois' Medicaid system dragged lawmakers into overtime. **By Tamara Strom**

[ SPRINGFIELD ] Staying two days past the scheduled adjournment date of June 30, the Illinois General Assembly negotiated feverishly to arrive at compromise funding of the state's Medicaid system. And when the House finally passed the health care facility assessment plan July 2 to complete the budget plan sent to Gov. Jim Edgar, the proposal was not all that different from Edgar's original plan. The program that passed in the House had passed in the Senate without incident June 29.

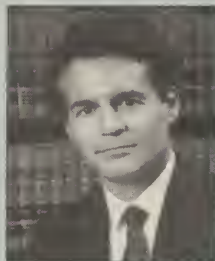
The slight alterations to Edgar's plan were sufficient to secure support from some suburban and downstate legislators who feared health care facilities in their districts would bear too much of the burden of treating indigent patients. Under the proposal, hospitals and nursing homes with rela-

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### INSIDE

**State Rep.  
Thomas J. Homer**  
sponsored legislation to  
eliminate the physician  
witness requirement at  
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U.S. Surgeon General Antonia Novello, M.D., (second row center) joins AMA delegates, spouses, children and others during a June 21 march to protest "Joe Camel." The AMA decries the symbol as the tobacco industry's effort to lure young people to try tobacco products.

## Frustration characterizes AMA annual meeting

**AMA annual meeting:** Delegates, increasingly frustrated with the current health care debate climate, direct the AMA to become "proactive." **By Kevin O'Brien**

[ CHICAGO ] An attack on "Joe Camel," consideration of the ethics of physician self-referral and caring for the poor, and pronouncements on abortion policy captured the headlines during the American Medical Association House of Delegates' annual meeting June 21-25 in Chicago.

Behind those headlines burned physicians' frustration with increasing government regulation, federal and state

attempts to establish universal health care and accusations that physicians are responsible for increasing health care costs. Much of this frustration boiled over in testimony from and debate by delegates who believe the AMA's effectiveness on these issues is continuing to wane.

Delegates adopted several resolutions that directed the Board of Trustees and senior management toward a more activist posture in Washington, in public education and in health care reform. "Proactive" was a term constantly heard in the Hilton Hotel and Towers corridors. One thing was certain: The delegates came to be heard.

The Illinois delegation can claim a strong measure of success at this year's gathering. Of the 22 Illinois resolutions considered by the House, nine were adopted or adopted as amend-

ed, four had a substitute resolution adopted, five were referred to the Board of Trustees and two had board reports adopted in place of the resolutions. Only two were not adopted. Several members of the Illinois delegation had prominent roles at the meeting, including Robert M. Vanecko, M.D., of Chicago, who chaired Reference Committee G; and Harold L. Jensen, M.D., of Harvey, who served on the Reference Committee on Constitution and Bylaws.

Finally, the House of Delegates saluted Illinois family physician John J. Ring, M.D., of Mundelein, as he completed his year as AMA president. ■

*For more detailed information about the successes of Illinois-sponsored measures at the meeting, see AMA coverage beginning on page 16.*

### ISMS BEHIND THE SCENES

## MEDIA OUTREACH BOOSTS LOBBYING EFFORTS

**By Ginny Thiersch**

[ CHICAGO ] The Illinois State Medical Society vigorously opposed two bills promising "free health care" in the recently concluded session of the Illinois General Assembly. Physicians and legislative staff targeted these simplistic yet costly and ineffective proposals for defeat.

Almost as soon as the ISMS annual meeting adjourned in April - a meeting that saw the Society's adoption of 10 principles of health

care reform - new ISMS President Arvind K. Goyal, M.D., testified against the proposal at a joint hearing of the House and Senate committees where the bills would be heard.

When the Society became aware of plans by supporters of the group to demonstrate outside the Society's Springfield office May 13, a "first strike" media plan went into effect. A press conference in Springfield on May 11 fea-

(Continued on page 22)



# IHA suing Illinois Cost Containment Council over hospital data access

**DATA:** The Illinois Hospital Association filed suit against the Illinois Health Care Cost Containment Council claiming the state agency is unlawfully restricting hospitals' review of discharge data they submit to the council. **By Tamara Strom**

[ MURPHYSBORO ] The Illinois Health Care Cost Containment Council chalked up a small victory July 6 when it secured a change of venue to Springfield for its court battle against the Illinois Hospital Association. The council also moved to vacate the suit IHA had filed against the state agency June 25 in Jackson County First Judicial Circuit Court, but a judge upheld a temporary restraining order prohibiting the council from releasing further data reports until Aug. 3. Joining IHA in the suit are two IHA-member hospitals — Memorial Hospital in Carbondale and St. Elizabeth's Hospital in Belleville.

"It's a minor victory," council Executive Director John Noak said of the change of venue.

In the suit, IHA cites as unfair new rules governing how hospitals review

their own data before the council publishes it in public reports. The new rules were formally adopted this spring by the council, with IHA representatives present. The hospital association representative to the council did not object to the rules at that time, said council Chairman Johanna Lund.

In fact, Lund said she was "surprised and disappointed" that IHA filed a lawsuit. "A lawsuit, in our opinion, is not a way to handle a grievance," Lund told *Illinois Medicine*. "This isn't the way you do business. There has been ample opportunity for discussion, and the council has followed appropriate procedures for rulemaking. But perhaps this is something that now needs to be settled in the courts."

Under the new rules, hospitals can review their data for free at the council's

offices. If hospitals want their data on a computer disk, they must pay \$345 for the four quarterly reports, Noak said. The new rules only restrict IHA from receiving the data as an agent for its members, he said.

At issue is the council's contention that IHA inappropriately released physician- and patient-identified data through its COMPdata system to competing hospitals. IHA charges its member hospitals a subscription fee to receive the enhanced discharge information through COMPdata. The council determined last fall that releasing ZIP code-specific patient information and physician identifiers ignores necessary confidentiality safeguards. The Illinois State Medical Society particularly took issue with the release of physician identifiers, saying access to this information by competing

hospitals could ultimately lead to economic credentialing.

IHA also contends in the suit that the council did not find serious errors in the data that was about to be published, and that without IHA review, incorrect reports would have been released to the public. Lund disputes these claims as "erroneous allegations." Noak added that several of IHA's claims that it found errors in the data are "inaccurate."

"In most cases, the errors were found by us working with individual hospitals," he said. "Our contention is that [IHA's] concern is not with the review of the data at all but with the data they need for their COMPdata system. We offered to let IHA have access to the data to review for their members if they didn't use it for COMPdata, and they turned that down." ■

## IDPH will seek repeal of Illinois Clinical Lab Act

[ SPRINGFIELD ] Come November, Illinois physicians may have one less set of clinical laboratory regulations to worry about. The Illinois Department of Public Health has decided to ask the General Assembly to repeal the Illinois Clinical Laboratory Act during the fall veto session.

IDPH based its decision on provisions of the Illinois Act that defer to any federal regulations that may be enacted. Now that the federal Clinical Laboratory Improvement Amendments are in effect, the department felt attempting to enforce even parts of the Illinois Act simultaneously with the CLIA rules would be duplicate regulation, said Rebecca Freidman Zuber of IDPH.

"CLIA is not a payment program; it's a federal licensing program," Zuber said. "Physicians must get a certificate and comply with the regulations to participate in the program. It's inherently duplicative of any state licensing activity."

Enforcing both the Illinois Act and CLIA would result in the state's "paying probably half the cost out of general revenue funds for our certification process," she said. Under CLIA, the federal government will reimburse IDPH for the regulation activities it undertakes to implement the federal rules.

"Why should the state of Illinois subsidize a federal licensing program out of general revenue funds, especially in these tight budget times?" Zuber asked.

The Illinois State Medical Society supports IDPH's decision to ask for repeal of the Act, said Richard Sassetti, M.D., chairman of the Society's Committee on Blood Banking and Laboratory Services. "ISMS is not particularly thrilled about CLIA," he said. "But we are anxious to relieve physicians of a dual obligation. We're favoring only one inspection and since we don't have an option with the federal inspection, we should move to get rid of the state regulations to avoid duplicative regulation."

"It was hoped when the Illinois Act was passed that it would ultimately meet

[U.S. Health Care Financing Administration] regulations for granting deemed status," Dr. Sassetti added. In that event, the Illinois Act, which is more lenient in some respects than CLIA, could have been enforced. But the two pieces of legislation are so different it is unlikely the federal government would allow Illinois to implement its program in place of CLIA, Dr. Sassetti said.

He cautioned, however, that even if the Illinois Act is repealed, physicians still must comply with CLIA regulations. Doctors performing even simple tests, including dipstick urinalysis, in office labs must register and obtain a certificate from HCFA to continue operating their labs legally. Even if physicians do not charge patients specifically for the simple test, they must register with the federal government.

The deadline for receiving a certificate is Sept. 1. Physicians who completed the mandatory HCFA lab survey will automatically receive a certificate application; those physicians who failed to complete the survey should do so as soon as possible. To receive a form, contact the ISMS Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. ■

## Blue Cross: Physicians must advocate mammography

[ CHICAGO ] Blue Cross and Blue Shield of Illinois is urging physicians to counsel their patients on the importance of mammography, citing a recent study that showed few women are seeking the tests. Less than 14 percent of women over 40 and 16 percent of women over 50 have ever had a mammogram, Blue Cross officials said.

Statistics are based on the number of claims for mammograms submitted by 26,227 women during the years 1990 and 1991, officials said. Only 3,662 women filed claims for mammography during that period, despite the fact that insurance coverage of mammography is mandated by Illinois law.

"The figures show we have to raise the consciousness of women and their doctors," said Arnold Widen, M.D., Blue Cross medical director. "Mammography can only help if women follow the recommended guidelines. Clearly, more doctors should urge women to undergo regular mammograms, and women must follow through on the doctor's orders."

"Women may be apprehensive about having a mammogram because of fear, anxiety and misinformation," said oncologist Burton Vanderlaan, M.D., a Blue Cross medical director. He said studies have shown that breast cancer death rates could be decreased by 30 percent if women followed National Cancer Institute guidelines for regular mammography testing.

Dr. Vanderlaan said that women and physicians both need to improve their communication on mammography to ensure that signs of breast cancer are detected early.

"Women and doctors need to work in partnership," he said. "Women need to take more control of their health, and doctors need to be more diligent in seeing that their patients are undergoing regular mammography."

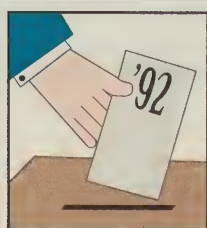
According to the American Cancer Society, breast cancer will strike 180,000 women in the United States this year and will kill 46,000. ■

## OSHA reminder

[ CHICAGO ] Physicians must now be in complete compliance with all phases of the U.S. Occupational Health and Safety Administration's bloodborne pathogen standard. The final deadline was July 6.

All physician offices must have a written exposure control plan in place, and employees must be trained in the mechanics of infection control. Anyone who comes in contact with blood and body fluids should have ready access to

## PHYSICIAN FACTS



**What two issues do you think will be most important in determining your support in the November 1992 presidential election?**

Issue	All respondents	Republicans	Democrats	Independents
The economy	50%	55%	46%	51%
Health care	25%	24%	27%	24%
Taxes	11%	12%	10%	11%
Jobs	8%	6%	10%	8%
Education	7%	8%	8%	7%
Foreign policy/aid	5%	7%	3%	6%
Abortion	4%	5%	3%	4%

Note: Total responses exceed 100% because respondents were asked to name two issues.  
Source: Kaiser/Commonwealth, 1992

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## Handout explains ISMS principles of health care reform

This issue of *Illinois Medicine* includes a handout explaining the Society's policy on health care reform. Adopted by the ISMS House of Delegates in April, these principles can shape the debate on reform in Illinois and nationally.

The handout details the Society's guidelines for health care reform, a topic that will highlight this year's elections. Please share it with your staff, your patients, your family and your colleagues.

Additional copies of this handout are available from ISMS.

protective clothing such as masks, gloves, gowns and eyewear. In addition, any employee who chooses to have the hepatitis B vaccination series should have at least begun it.

For more information on the OSHA regulations, contact the Illinois State Medical Society's department of medical services at (312) 782-1654 or (800) 782-ISMS. ■

## Free patient booklets keep seniors informed

[ CHICAGO ] A free booklet developed for the Illinois State Medical Society's "Partners for Health" outreach program is now available to physicians to distribute to their senior patients. The Personal Health Records allow seniors to keep track of doctors' visits, prescribed and over-the-counter medications, drug reactions, doctors' instructions and patient questions.

ISMS members can receive unlimited copies of the booklets by writing to the ISMS public relations department, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602, or by calling (312) 782-1654 or (800) 782-ISMS. ■

## CDC will not change draft HIV recommendations

[ ATLANTA ] On June 18 the U.S. Centers for Disease Control informed state public health officials that each state must set up guidelines to prevent transmission of HIV and hepatitis B in health care settings. Inherent in this directive is the CDC's decision to allow states to establish which – if any – procedures and circumstances could place patients at risk.

In a letter from CDC Director William L. Roper, M.D., the agency told states they still must meet the Oct. 28 deadline to implement CDC guidelines or an equivalent set by the U.S. Department of Health and Human Services. Failure to meet the deadline will result in loss of

federal funding for public health programs, HHS said.

"After careful review and consideration," CDC decided not to modify its draft recommendations on preventing transmission of HIV and HBV from health care workers to patients during potentially exposure-prone procedures. The draft recommendations, released July 12, 1991, are now final.

In reviewing individual state guidelines, CDC "will give appropriate consideration to those states that decide that exposure-prone invasive procedures are best determined on a case-by-case basis," Dr. Roper said.

To conform with the federal law states

must forward to CDC by the Oct. 28 deadline either certification that guidelines identical or similar to CDC recommendations have been implemented or a request for an extension to implement such guidelines. Illinois, during last year's legislative session, enacted S.B. 999, a piece of compromise legislation aimed at meeting this federal requirement. Gov. Jim Edgar appointed a task force comprising physicians, other health care workers and members of the public to recommend how to implement the state law. Although the governor has yet to act on the task force's report, many of the group's recommendations mirror those made by CDC last summer.

A May 15 report in CDC's *Morbidity and Mortality Weekly Report* announced that ongoing look-back studies of 15,000 patients treated by HIV-infected health care workers have not produced further evidence of transmission to at-risk patients. The case of the Florida dentist who probably transmitted HIV to five of his patients remains the only instance of such infections, Dr. Roper said. "These findings reinforce the statements in the July 12 guidelines that the risk of HIV transmission from a [health care worker] to a patient is small," he said. Dr. Roper also said mandatory testing of health care workers is "not justified." ■

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0.2 MG/HR

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Patient-preferred 7 to 1 for convenience compared with oral nitrates  
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Easy-to-handle nonadhesive tab

As with all nitroglycerin medications, side effects may occur with Transderm-Nitro, the most common of which is headache. All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. Please consult brief summary of Prescribing Information on following page.

**Transderm-Nitro**<sup>®</sup>  
nitroglycerin 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr\*



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**At the heart of nitrate compliance**

\*Formerly described as 2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr.

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# Universal health opponents claim victory

**UNIVERSAL HEALTH:** Supporters of a Canadian model failed in several attempts to advance legislation mandating a single-payer, tax-funded health delivery system for Illinois. **By Tamara Strom**

[ SPRINGFIELD ] Physicians and their allies who oppose a single-payer, tax-funded health care system in Illinois succeeded in convincing legislators that enacting such a system would result in fiscal disaster for the state.

Two bills calling for the creation of such a system failed to clear their houses of origin during the first half of the session. At the session's close July 2,

attempts to amend the system onto vehicle bills also ended in failure, with the Senate vehicle tabled and the House bill never being called for a vote.

"Physicians all over the state helped convince the General Assembly not to approve a radical and costly 'universal' health care system for Illinois," said Illinois State Medical Society President Arvind K. Goyal, M.D. "Enacting a

Canadian-style health delivery system in this state would create a fiscal chaos and limit access to those who need medical care. While we're happy with the results of our efforts this session, we won't be lulled into a false sense of security. We know the universal health care supporters will push their agenda again; the issue is far from dead."

After a narrow loss last year, universal

health advocates Rep. Anthony L. Young (D-Chicago) and Sen. Margaret Smith (D-Chicago) again introduced bills creating a single-payer system for Illinois. Because it is an election year, observers noted that lawmakers were eager to advance the popular health care reform measures as far as possible. Several public hearings and heavy lobbying by ISMS on members' behalf and efforts by the insurance industry and business groups, however, convinced the legislators that a single-payer system is not financially feasible. Although both H.B. 2774 and S.B. 1495 won approval in committee, neither was able to garner enough votes to pass on the House or Senate floor.

While the message of revamping the state's health care system was politically saleable this session, the massive tax increases necessary to fund a single-payer delivery system were not. With the entire General Assembly up for re-election this fall — many members in newly drawn legislative districts — lawmakers shied away from raising taxes of any kind, even "sin" taxes. Providing universal health care to all Illinois residents would cost about \$54 billion, double the state's current total budget, according to supporters' estimates. To fund the system, the legislature would have to vote to triple personal income taxes and add

(Continued on page 22)

## • Every Transderm-Nitro patch has the exclusive easy-open tab

Easy to apply —  
Easy to remove

Available in four  
convenient dosages

Patches not shown  
actual size

Transderm-Nitro®  
nitroglycerin  
Transdermal Therapeutic System

### Revised Dosage Information

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

#### INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention of angina pectoris due to coronary artery disease. Tolerance to the antianginal effects of nitrates (measured by exercise stress testing) has been shown to be a major factor limiting efficacy when transdermal nitrates are used continuously for longer than 12 hours each day. The development of tolerance can be altered (prevented or attenuated) by use of a noncontinuous (intermittent) dosing schedule with a nitrate-free interval of 10-12 hours. Controlled clinical trial data suggest that the intermittent use of nitrates is associated with decreased exercise tolerance, in comparison to placebo, during the last part of the nitrate-free interval; the clinical relevance of this observation is unknown, but the possibility of increased frequency or severity of angina during the nitrate-free interval should be considered. Further investigations of the tolerance phenomenon and best regimen are ongoing. A final evaluation of the effectiveness of the product will be announced by the FDA.

#### CONTRAINDICATIONS

Allergic reactions to organic nitrates are extremely rare, but they do occur. Nitroglycerin is contraindicated in patients who are allergic to it. Allergy to the adhesives used in nitroglycerin patches has also been reported, and it similarly constitutes a contraindication to the use of this product.

#### WARNINGS

The benefits of transdermal nitroglycerin in patients with acute myocardial infarction or congestive heart failure have not been established. If one elects to use nitroglycerin in these conditions, careful clinical or hemodynamic monitoring must be used to avoid the hazards of hypotension and tachycardia.

A cardioverter/defibrillator should not be discharged through a paddle electrode that overlies a Transderm-Nitro patch. The arcing that may be seen in this situation is harmless in itself, but it may be associated with local current concentration that can cause damage to the paddles and burns to the patient.

#### PRECAUTIONS

##### General

Severe hypotension, particularly with upright posture, may occur with even small doses of nitroglycerin. This drug should therefore be used with caution in patients who may be volume depleted or who, for whatever reason, are already hypotensive. Hypotension induced by nitroglycerin may be accompanied by paradoxical bradycardia and increased angina pectoris.

Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

As tolerance to other forms of nitroglycerin develops, the effect of sublingual nitroglycerin on exercise tolerance, although still observable, is somewhat blunted.

In industrial workers who have had long-term exposure to unknown (presumably high) doses of organic nitrates, tolerance clearly occurs. Chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitrates from these workers, demonstrating the existence of true physical dependence.

Several clinical trials in patients with angina pectoris have evaluated nitroglycerin regimens which incorporated a 10-12 hour nitrate-free interval. In some of these trials, an increase in the frequency of anginal attacks during the nitrate-free interval was observed in a small number of patients. In one trial, patients demonstrated decreased exercise tolerance at the end of the nitrate-free interval. Hemodynamic rebound has been observed only rarely; on the other hand, few studies were so designed that rebound, if it had occurred, would have been detected. The importance of these observations to the routine, clinical use of transdermal nitroglycerin is unknown.

##### Information for Patients

Daily headaches sometimes accompany treatment with nitroglycerin. In patients who get these headaches, the headaches may be a marker of the activity of the drug. Patients should resist the temptation to avoid headaches by altering the schedule of their treatment with nitroglycerin, since loss of headache may be associated with simultaneous loss of antianginal efficacy.

Treatment with nitroglycerin may be associated with lightheadedness on standing, especially just after rising from a recumbent or seated position. This effect may be more frequent in patients who have also consumed alcohol.



0.1 mg/hr...  
Formerly described as 2.5 mg/24 hr



0.2 mg/hr...  
Formerly described as 5 mg/24 hr



0.4 mg/hr...  
Formerly described as 10 mg/24 hr



0.6 mg/hr...  
Formerly described as 15 mg/24 hr

After normal use, there is enough residual nitroglycerin in discarded patches that they are a potential hazard to children and pets.

A patient leaflet is supplied with the systems.

#### Drug Interactions

The vasodilating effects of nitroglycerin may be additive with those of other vasodilators. Alcohol, in particular, has been found to exhibit additive effects of this variety.

Marked symptomatic orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustments of either class of agents may be necessary.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

No long-term animal studies have examined the carcinogenic or mutagenic potential of nitroglycerin. Nitroglycerin's effect upon reproductive capacity is similarly unknown.

#### Pregnancy Category C

Animal reproduction studies have not been conducted with nitroglycerin. It is also not known whether nitroglycerin can cause fetal harm when administered to a pregnant woman or whether it can affect reproductive capacity. Nitroglycerin should be given to a pregnant woman only if clearly needed.

#### Nursing Mothers

It is not known whether nitroglycerin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when nitroglycerin is administered to a nursing woman.

#### Pediatric Use

Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to nitroglycerin are generally dose-related, and almost all of these reactions are the result of nitroglycerin's activity as a vasodilator. Headache, which may be severe, is the most commonly reported side effect. Headache may be recurrent with each daily dose, especially at higher doses. Transient episodes of lightheadedness, occasionally related to blood pressure changes, may also occur. Hypotension occurs infrequently, but in some patients it may be severe enough to warrant discontinuation of therapy. Syncope, crescendo angina, and rebound hypertension have been reported but are uncommon.

Extremely rarely, ordinary doses of organic nitrates have caused methemoglobinemia in normal-seeming patients. Methemoglobinemia is so infrequent at these doses that further discussion of its diagnosis and treatment is deferred (see Overdosage).

Application-site irritation may occur but is rarely severe.

In two placebo-controlled trials of intermittent therapy with nitroglycerin patches at 0.2 to 0.8 mg/hr, the most frequent adverse reactions among 307 subjects were as follows:

	Placebo	Patch
Headache	18%	63%
Lightheadedness	4%	6%
Hypotension, and/or syncope	0%	4%
Increased angina	2%	2%

#### OVERDOSAGE

##### Hemodynamic Effects

The ill effects of nitroglycerin overdose are generally the result of nitroglycerin's capacity to induce vasodilatation, venous pooling, reduced cardiac output, and hypotension. These hemodynamic changes may have protean manifestations, including increased intracranial pressure, with any or all of persistent throbbing headache, confusion, and moderate fever; vertigo; palpitations; visual disturbances; nausea and vomiting (possibly with colic and even bloody diarrhea); syncope (especially in the upright posture); air hunger and dyspnea, later followed by reduced ventilatory effort; diaphoresis, with the skin either flushed or cold and clammy; heart block and bradycardia; paralysis; coma; seizures; and death.

Laboratory determinations of serum levels of nitroglycerin and its metabolites are not widely available, and such determinations have, in any event, no established role in the management of nitroglycerin overdose.

No data are available to suggest physiological maneuvers (e.g., maneuvers to change the pH of the urine) that might accelerate elimination of nitroglycerin and its active metabolites. Similarly, it is not known which, if any, of these substances can usefully be removed from the body by hemodialysis.

No specific antagonist to the vasodilator effects of nitroglycerin is known, and no intervention has been subject to controlled study as a therapy of nitroglycerin overdose. Because the hypotension associated with nitroglycerin overdose is the result of venodilation and arterial hypovolemia, prudent therapy in this situation should be directed toward an increase in central fluid volume. Passive elevation of the patient's legs may be sufficient, but intravenous infusion of normal saline or similar fluid may also be necessary.

The use of epinephrine or other arterial vasoconstrictors in this setting is likely to do more harm than good.

In patients with renal disease or congestive heart failure, therapy resulting in central volume expansion is not without hazard. Treatment of nitroglycerin overdose in these patients may be subtle and difficult, and invasive monitoring may be required.

#### Methemoglobinemia

Nitrate ions liberated during metabolism of nitroglycerin can oxidize hemoglobin into methemoglobin. Even in patients totally without cytochrome b<sub>5</sub> reductase activity, however, and even assuming that the nitrate moieties of nitroglycerin are quantitatively applied to oxidation of hemoglobin, about 1 mg/kg of nitroglycerin should be required before any of these patients manifests clinically significant ( $\geq 10\%$ ) methemoglobinemia. In patients with normal reductase function, significant production of methemoglobin should require even larger doses of nitroglycerin. In one study in which 36 patients received 2-4 weeks of continuous nitroglycerin therapy at 3.1 to 4.4 mg/hr, the average methemoglobin level measured was 0.2%; this was comparable to that observed in parallel patients who received placebo.

Notwithstanding these observations, there are case reports of significant methemoglobinemia in association with moderate overdoses of organic nitrates. None of the affected patients had been thought to be unusually susceptible.

Methemoglobin levels are available from most clinical laboratories. The diagnosis should be suspected in patients who exhibit signs of impaired oxygen delivery despite adequate cardiac output and adequate arterial pO<sub>2</sub>. Classically, methemoglobinemic blood is described as chocolate brown, without color change on exposure to air.

When methemoglobinemia is diagnosed, the treatment of choice is methylene blue, 1-2 mg/kg intravenously.

#### DOSAGE AND ADMINISTRATION

The suggested starting dose is between 0.2 mg/hr\*, and 0.4 mg/hr\*. Doses between 0.4 mg/hr\* and 0.8 mg/hr\* have shown continued effectiveness for 10-12 hours daily for at least one month (the longest period studied) of intermittent administration. Although the minimum nitrate-free interval has not been defined, data show that a nitrate-free interval of 10-12 hours is sufficient (see INDICATIONS AND USAGE). Thus, an appropriate dosing schedule for nitroglycerin patches would include a daily patch-on period of 12-14 hours and a daily patch-off period of 10-12 hours.

Although some well-controlled clinical trials using exercise tolerance testing have shown maintenance of effectiveness when patches are worn continuously, the large majority of such controlled trials have shown the development of tolerance (i.e., complete loss of effect) within the first 24 hours after therapy was initiated. Dose adjustment, even to levels much higher than generally used, did not restore efficacy.

#### PATIENT INSTRUCTIONS FOR APPLICATION OF SYSTEM

A patient leaflet is supplied with each carton.

#### HOW SUPPLIED

Transderm-Nitro System*	Total Nitro-glycerin in System	System Size	Carton Size
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0.2 mg/hr	25 mg	10 cm <sup>2</sup>	30 Systems...NDC 57267-905-26 **30 Systems...NDC 57267-905-42 **100 Systems...NDC 57267-905-30
0.4 mg/hr	50 mg	20 cm <sup>2</sup>	30 Systems...NDC 57267-910-26 **30 Systems...NDC 57267-910-42 **100 Systems...NDC 57267-910-30
0.6 mg/hr	75 mg	30 cm <sup>2</sup>	30 Systems...NDC 57267-915-26 **30 Systems...NDC 57267-915-42 **100 Systems...NDC 57267-915-30

\*\* Institutional Pack

\*Rated release in vivo. Release rates were formerly described in terms of drug delivered per 24 hours. In these terms, the supplied Transderm-Nitro systems would be rated at 2.5 mg/24 hr (0.1 mg/hr), 5 mg/24 hr (0.2 mg/hr), 10 mg/24 hr (0.4 mg/hr), and 15 mg/24 hr (0.6 mg/hr).

Do not store above 86°F (30°C).

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#### References:

- Brady EM, Gold OG, Rosenbach HJ. Antianginal efficacy of transdermal nitroglycerin and oral nitrates: The ACTION Study. *Cardiovasc Rev Rep*. October 1988; 40-44.

## Cook County to vote on universal health care

**REFERENDUM:** An advisory referendum on the November ballot will ask Cook County voters about a universal health care system. **By Kevin O'Brien**

[ CHICAGO ] Cook County voters will have the chance to express their preference on the issue of a single-payer, government-run health care system this November.

The Cook County Board of Commissioners June 15 voted 11-4 to place an advisory referendum on the November ballot. Language introduced in an ordinance by Commissioner John H. Stroger Jr. (D-Chicago) will ask voters, "Should the state of Illinois urge the Congress and the president of the United States to enact a publicly funded national health insurance program that provides comprehensive health care for all citizens while giving everyone the right to choose their own hospital, doctor or other health professional?"

Four Republican commissioners — Carl R. Hansen of Mt. Prospect, Mary M. McDonald of Lincolnwood, Herbert T. Schumann Jr. of Palos Hills and Richard A. Siebel of Northbrook — voted against the ordinance.

The ordinance language is identical to that supported by Illinois Treasurer Patrick Quinn in legislation that was introduced during the General Assembly spring session in bills that failed to clear committee.



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restrictions.

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**Excellent patient acceptance.**

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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Tablet for tablet, the most potent analgesic you can phone in.

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)  
1. Data on file, Knoll Pharmaceuticals  
2. Standard industry new prescription audit

Please see brief summary of prescribing information on adjacent page.





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**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain. **CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone. **WARNINGS: Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. **Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS: Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytic agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy: Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE: Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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The American Fracture Association has re-elected **George R. Ruiz, M.D.**, of Flossmoor, as its president for 1992. Dr. Ruiz, a practicing orthopedic surgeon in the south suburbs for more than 20 years, is a member of the American Academy of Orthopaedic Surgeons and the American College of Surgeons. He is a member of the medical staffs of South Suburban Hospital in Hazelcrest, and Ingalls Memorial Hospital in Harvey.

**Ron W. Lee, M.D.**, of Maywood, was named vice chairman of the Emergency Medical Services Commission of the Metropolitan Chicago Healthcare Council. Dr. Lee is currently director of emergency medical services at Loyola University Medical Center in Maywood. The commission coordinates the activities of a variety of governmental and voluntary agencies to assure that an effective emergency medical system is in place throughout the Chicago area. Dr. Lee also chairs the MCHC Hospitals Committee.

**Roger C. Bone, M.D.**, of River Forest, was elected vice president for medical affairs and dean of Rush Medical College by the Rush-Presbyterian-St. Luke's Medical Center Board of Trustees. Dr. Bone, the Ralph C. Brown, M.D., Professor, is chairman of the department of medicine and chief of the section of pulmonary care medicine at Rush in Chicago. He had served as interim vice president for medical affairs and acting dean of Rush Medical College since April 1991. Dr. Bone received his medical degree from the University of Arkansas Medical School. He joined the Rush faculty and staff as chairman of medicine in 1984.

**William H. Langewisch, M.D.**, of Rockford, retired as associate dean for academic and hospital affairs at the University of Illinois College of Medicine at Rockford after 38 years of professional and community service. One of the original faculty members, Dr. Langewisch served as coordinator of pediatrics and assistant dean for academic affairs before being named associate dean in 1985. He received his medical degree from Northwestern University Medical School and served in the Army during World War II and in the Air Force during the Korean War. He began his Rockford pediatrics practice in 1953.

**Lawrence S. Ross, M.D.**, of Chicago, was appointed head of the department of urology at the University of Illinois College of Medicine at Chicago. Dr. Ross will be the first head of the urology department, which was formerly a division of surgery. He is currently Clarence C. Saelhof Professor of Urology and chief of the Division of Urology, and chief of service at the University of Illinois Hospital.

**Kenneth D. Schmidt, M.D.**, of Deerfield, was appointed vice president of medical affairs at Holy Family Hospital. The position was created through Holy Family's recent affiliation with Rush-Presbyterian-St. Luke's Medical Center. Dr. Schmidt will be responsible for implementing the clinical aspects of the venture agreement between the two institutions. He will also hold the position of associate dean of Rush Medical

College. Dr. Schmidt joined Holy Family in 1971.

The Holland Society awarded **Robert R. Schenck, M.D.**, of Chicago, its Distinguished Achievement Medal at its recent annual meeting. Dr. Schenck was honored for excellence in microsurgery. He is an assistant professor and director of the section of hand surgery in the departments of plastic and orthopedic surgery at Rush-Presbyterian-St. Luke's Medical Center, Chicago. ■



MARK GARRETT/PCI

**VAINO RAAG, M.D.**, (left) a family physician from Addison, accepts a 1992 Outstanding Team Physician award from DuPage County Medical Society President **Richard F. Bulger, M.D.**, at the society's May meeting.

## Blue Cross Blue Shield



# REPORT

## FOR *Illinois Physicians*

### A Blue Shield Guide for Completing The HCFA 1500 Form

To assist your staff in completing the new, revised HCFA-1500 claim form, Blue Cross and Blue Shield of Illinois (BCBSI) recently mailed A Blue Shield Guide for Completing The HCFA 1500 Form to your office. To ensure the quickest reimbursement of your Blue Shield claims, BCBSI recommends use of A Blue Shield Guide for Completing The HCFA 1500 Form as soon as possible for the most efficient handling of your claims. If you have any questions, please contact one of our representatives at (312) 938-6187, (312) 938-6269, or (312) 938-6517.

#### Place of Service Codes

As published in the June 5, 1992 *Blue Cross Blue Shield Report for Illinois Physicians*, Blue Shield is now accepting for the submission of your paper claims the new two-digit Place of Service (POS) codes required by Medicare B. Please continue to use the one-digit POS codes for the submission of your electronic claims until further notice.

#### Benefit Changes Announced for American Stores

Effective July 1, 1992, employees of American Stores and their eligible dependents began participating in our new point-of-service managed care program, Managed Care Network Preferred (MCNP).

#### Precertification: Board of Education

*Reminder:* Please continue to follow normal precertification procedures for your Board of Education patients. As you may already be aware, precertification procedures for your City of Chicago patients recently changed. Please note that these recent changes apply to your City of Chicago patients only and not your Board of Education patients. If you have any further questions, please contact one of our Provider Assistance Unit representatives at (312) 938-7340.

#### Important Telephone Numbers for Professional Providers

HMO of Illinois (Enrollment)	(312) 938-7453
HMO of Illinois (Claim Inquiries)	(800) 892-2803
Managed Care Network Preferred (MCNP)	(312) 938-7433
Medicare Part B	(618) 997-3190
Provider Assistance Unit	(312) 938-7340
Provider File Changes	(312) 938-6001

*Request for Blue Shield Provider Number, Change of Address,  
Tax ID Change, Name Change*

(This report is published as a service to the physicians of Illinois.)  
(7/17/92)



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## EDITORIAL

# Elvis, universal health and creative education

A teenager we know has a goldfish she has named Elvis – because it won't die, no matter what.

The same moniker might be applied to the idea of universal health – it will not go away, no matter how dead it appears to be at the moment. We have this on the authority of one of the leaders of the movement for a Canadian-style system in Illinois, who spent some time in a recent radio interview attacking the medical society as obstructionist and negative. The concept of universal health, he threatened, will return to the General Assembly.

And organized medicine's dedication to free-market enterprise and our priority on our patients' health and well-being will return as well. Elsewhere in this issue is an account of the public and behind-the-scenes efforts of the medical society in what was an all-out educational effort. Our audiences were state legislators, our members, the media and the public. Our lesson was the economic and quality-of-care realities in the "pie-in-the-sky" universal health proposal the General Assembly was considering.

We cannot afford to take a break from this effort even now, with the legislature

adjourned until fall and the two bills supporting the concept seemingly, like Elvis, gone to their reward.

Because the idea of "free" health care, as simplistic and misleading as it is, will continue to haunt the debate on health care reform. The hidden cost in massive tax increases this "free" care will engender is hard to see in the legislative and promotional language the bills' supporters have been using. So we must continue to educate.

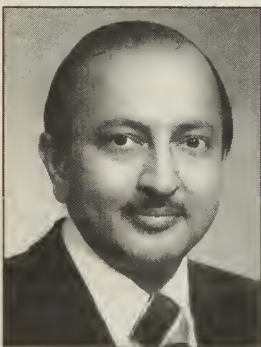
Included with this issue of *Illinois Medicine* is an educational tool. The handout details the Society's recently adopted principles of health care reform. It is designed to be shared with anyone you think will benefit from reading organized medicine's concerns about the reform movement. Additional copies are available from the medical society – and we'll want to hear how you use them in your community.

Because even though it's summertime, school's not out on the issue of health care reform. And the concept of "free" government-provided health care is probably spending the summer hanging out at the mall getting its sideburns trimmed with you-know-who.

## PRESIDENT'S LETTER

# Just as chickens come home to roost, TB returns to kill

By Arvind K. Goyal, M.D.



*"There may be physicians in our generation who have never seen a case of TB."*

Three men of different occupations looked at the Grand Canyon. The artist commented, "What a wonderful design!" The clergyman announced, "Yet another glory of God!" And the cowboy concluded, "A heck of a place to lose a cow!"

There's no difference of opinion, no matter who looks at the latest tuberculosis statistics: The disease is making a comeback, nationally and here in Illinois. With your good work, improved living conditions, and effective drug therapy, TB, after killing many people in the past, had been on the decline for 30 years before raising its ugly head during this past decade.

The incidence of TB has increased progressively since 1986: 1,192 cases were reported statewide in 1991, and 477 cases have been reported during the past five months this year. The sharpest increase occurred in suburban Cook County, but the disease affects all Illinois communities: 285 cases so far have been reported this year in Chicago; 82 in suburban Cook County; and 110 cases in downstate Illinois.

Anybody can catch TB, but those at highest risk are the close contacts of a patient with active TB – family, close friends, fellow workers, health care workers and others who regularly breathe the potentially infectious air. About a quarter of those exposed get infected. People with HIV, IV drug users, the homeless, racial and ethnic minorities, recent immigrants, residents of correctional institutions and nursing homes, and younger adults seem to get the disease more often.

A new strain of *tubercle bacilli*, Multiple Drug Resistant TB (MDR-TB) is resistant to the five primary drugs used to treat TB. Second-line drugs have not been readily available.

About 90 percent of the MDR-TB cases have occurred in immunocompromised patients, especially people with HIV; 90 percent of them die within four to 16 weeks after diagnosis. Terrifying outbreaks have occurred in hospitals and prisons. Several residents, attending physicians and other staffers at Cook County Hospital have recently been found to be infected, underscoring the hazards and sacrifices that come with the job.

And now some refreshers: Symptoms and clinical findings alone are insufficient to make a diagnosis of TB, which is still dependent on screening with tuberculin skin test, chest x-ray and sputum AFB cultures. The tuberculin testing requires diligent follow-up. Chest x-rays are not popular. And sputum tests still take more than a few days.

The only available vaccine, BCG, is of questionable value. Research efforts have been low. No new tests or drugs to treat TB have been developed or introduced recently. And worse yet, the isolation facilities and sanitariums have been closed down, while other infection control measures may be lax in some institutions.

Effective chemotherapy of the source case, usually for six to nine months; precautions such as covering the mouth and nose when coughing or sneezing; adequate room ventilation; ultraviolet irradiation of air in the room and the use of masks may reduce the risk of transmission. Yet, these measures remain inconvenient, expensive and hard to comply with.

A sense of false security may have generated complacency amongst physicians as well as patients. There may be physicians in our generation who have never seen a case of TB. TB needs to get on their list of differential diagnoses quickly.

Public health officials have responded timely by their efforts to increase awareness of this disease, creating task forces to address the problems of rising TB incidences, maintaining tax-supported "TB districts" that provide "free" TB screening, treatment and contact tracing, and asking for increased funding for TB control programs and research.

We physicians who care for patients need to join in this crusade to contain and hopefully eliminate TB from our communities. That would require increased efforts at screening even our "healthy" patients of all ages for TB, treating those found to be infected or at high risk in accordance with existing protocols, reporting TB cases to local public health agencies for contact tracing and follow-up, and applying effective prevention strategies and precautions in our practices.

A TB epidemic must be prevented. We don't need more problems. We have enough of those for now.





"This is from City Hospital. Everyone born in 1931 is being recalled."

## GUEST EDITORIAL

# Welcome to the new Illinois Medicine

Welcome to the new *Illinois Medicine*. As you've probably already noticed, this issue has a new look. As chairman of the ISMS Board of Trustees' *Illinois Medicine* Committee, I'd like to tell you how and why we've made these changes.

Several years ago, *Illinois Medicine* was born as a result of an extensive member survey. The results of that survey revealed the membership's need for information relevant to the practice of medicine in our state. The membership also asked for news about the socioeconomic climate, statewide and nationally, as it relates to health care. Clinical information, the survey told us, was best imparted through other publications, usually those related directly to the reader's specialty. Implementing the data gathered from that survey meant a whole new way of presenting information to physicians in Illinois, and *Illinois Medicine* made its debut in January 1989.

Since then, *Illinois Medicine* has striven to provide accurate, balanced, useful and timely news for our readers. Because our focus has always been to "meet the needs of our readers," the survey that gave rise to the newspaper has also been refined and used to provide for the growth and development of *Illinois Medicine*. Last year we surveyed 1,000 of our readers to see how we could better meet their needs; you are looking at the results!

In terms of graphic presentation, we have redesigned the newspaper to focus on the priorities of our readers. Our new format provides more analysis and interpretation of events and issues, with the *Illinois* impact clearly stated. You

will find more news stories that are short and to the point and that highlight the *Illinois* angle. We'll include more in-depth reporting on the positions of ISMS regarding legislation, regulations and professional liability (which, our survey told us, is still our readers' No. 1 concern).

In keeping with that concern, we have expanded the insurance section of *Illinois Medicine*. Immediately following this page is a new section on the Exchange, with expanded coverage of malpractice trends and activities in *Illinois* and nationally.

Our overall goal throughout the process of redesigning *Illinois Medicine* has been to accommodate you, the busy doctor in *Illinois*. Shorter articles, a more concentrated emphasis on news, even a new typeface for headlines are not changes implemented for the sake of change, but changes to make it easier for you to get what you need and want from your Society's publication.

As you enjoy the new look for *Illinois Medicine*, remember our commitment to serve our readers is enhanced by any feedback we can get. One area where we

have not succeeded is in generating letters to the editor. We wonder if letters are outmoded; maybe we should have "call the editor," or "modern the editor." In the future we'll be testing several different methods to elicit reader response to our articles and editorials. Your reaction to our new look is important to us, and we will continue to attempt to meet your *Illinois* health care news needs. Please let us know how we are doing!



**Joan E. Cummings, M.D.**, is chairman of the *Illinois Medicine* Committee and a member of the ISMS Board of Trustees.

## LETTERS

### Strengthen laws on tinted car windows

In reference to your article on prescriptions for tinted car windows, the medical society should favor a strengthening of this law to prevent tinted car windows. The simple use of sunglasses quite adequately protects sensitive eyes. The illegal uses of tinted car windows far overshadow the infinitesimally small number of people who might genuinely be benefited by such windows.

— Boone Brackett, M.D.  
Oak Park

### Sponsor withdraws support of H.B. 3607

On May 26, 1992, I agreed to sponsor H.B. 3607, legislation amending the Criminal Code, that would remove the current statutory requirement that two physicians serve as witnesses to an execution by lethal injection and that a physician pronounce death following the execution. This legislation was the direct result of *Illinois* State Medical Society policy taken on this issue, which found this law in conflict with the ethical tenets of your profession.

As a paramedic, I understand your position regarding the current requirement for physician participation and take no issue with your ethical position. However, upon agreeing to sponsor your legislation, it was my understanding from ISMS that it was not intended to undermine the *Illinois* death penalty. Subsequently, positions taken by two medical organizations, other than ISMS, coupled with the position taken by the *Illinois* Attorney General and several state's attorneys, persuaded me otherwise.

On June 3, 1992, I received a fax from Dr. Ann Marie Dunlap consisting of a letter she had received from the American Medical Association suggesting that H.B. 3607 be amended to state that "no physician shall be permitted to participate or perform ancillary function in an execution." Secondly, on June 10, 1992, written and oral testimony was presented to the Senate Judiciary I Committee by Dr. Dunlap on behalf of the Subcommittee on Human Rights of the American College of Physicians requesting that the bill be amended with the same language as the AMA had recommended. This suggested amendment differed with the ISMS amendment that was offered in committee that would have excluded physicians from the secrecy provisions afforded to other persons engaged in the execution process. The testimony from Dr. Dunlap that physicians should be expressly prohibited from participating in executions differed from the ISMS position that there should be no statutory requirement that a physician be engaged by the state to be a witness or pronounce death in an execution.

Dr. Dunlap's testimony aroused

serious concern among my colleagues and myself as to whether or not the real intent of the AMA/ACP amendment, as well as the underlying bill, was to create insurmountable legal problems, thus eliminating the use of the death penalty. Our concern was confirmed by [a] statement issued by the Attorney General and several state's attorneys who have advised the Senate that H.B. 3607 would obstruct lawful executions in *Illinois*.

Frankly, Dr. Dunlap's communications with my office and the legislature only served, in my opinion, to confuse this matter. Her ardent testimony was not only confusing, but antagonized committee members who asked questions regarding her true intentions for the legislation. She filled out a witness slip opposing the bill, possibly because she believes ISMS did not go far enough with their legislation toward her ultimate goal to abolish the death penalty. Whatever Dr. Dunlap's motives, her testimony did little to promote the bill, but went a long way toward confusing the issue and causing serious concerns about its ultimate ramifications.

I have worked with the leadership and representatives of ISMS since my first election to the state Senate. While I have not always agreed with your positions, I have found yours to be an honest and forthright organization.

Unfortunately, the representations made by this physician apparently on behalf of the AMA and other physicians, have made it impossible to complete the task at hand. It appears that the ultimate objective of these groups is to go beyond your ethical position, with which I am sympathetic, to create a "back-door" abolition of the death penalty. This I cannot support. I believe that those such as John Wayne Gacy who committed heinous crimes against society should and must pay the ultimate price. I intend to continue to fight on behalf of my constituents to see that they do.

For these reasons, I today have withdrawn my sponsorship of H.B. 3607. Please believe this is an action I do not take lightly but feel compelled to do. I strongly suggest that ISMS re-evaluate the legislation in view of its legal implications.

— Sen. Robert M. Raica  
Chicago

*Illinois Medicine welcomes letters on topics of interest to our readers. Write us at Letters to the Editor, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602 or fax (312) 782-2023. Letters of any length will be considered for publication, but we reserve the right to edit for space.*



# "ISMIE's Risk Management Seminar On Cancer Was A Lifesaver ...Literally."

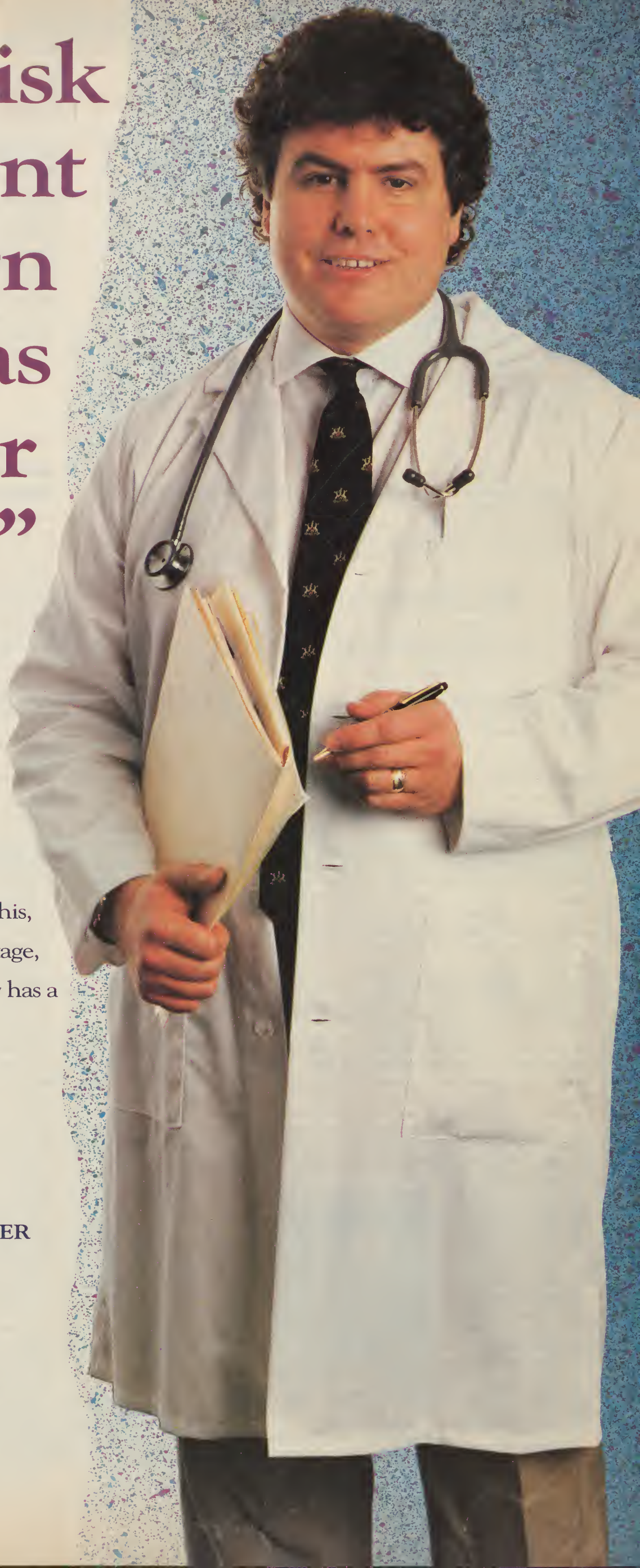
"I had just attended an ISMIE risk management seminar that dealt with the symptoms of cancer most commonly overlooked or misdiagnosed. Information presented at the seminar prompted me to ask questions that did not pertain to the patient's presenting complaint. Because of this, I was able to detect the cancer in an early stage, surgery was performed, and the patient now has a very good prognosis."

- John V. McInerney, D.O.

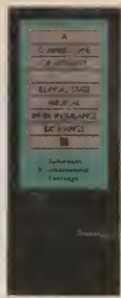
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Exchange promotes  
defendant  
reimbursement  
coverage

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# ISMIE Update

Exchange  
Q & A

PAGE 11

## Exchange continues history of fighting for physicians — and winning big

**AGGRESSIVE DEFENSE:** Exchange defense strategies developed in the 1970s serve physicians well today. **By Anna Brown**

[ CHICAGO ] When you find something that works, you stick with it. That's what the Illinois State Medical Inter-Insurance Exchange discovered about its innovative aggressive defense policy. It is a policy that has given physicians something to cheer about — fewer payouts and fewer trials.

"Only 3 percent of suits filed against Exchange policyholders go to trial, and of those, 75 percent are resolved in favor of the defendant," said Phillip D. Boren, M.D., Illinois State Medical Insurance Services chairman. "Further, the Exchange closes 81.4 percent of all claims without any indemnity payment. This is well above the national average of 67.5 percent. These statistics show that Exchange policyholders can be certain they will receive the best defense their premium dollar can buy."

Dr. Boren and E. Michael Kelly, an Exchange defense attorney, attribute the Exchange's success to its aggressive defense mechanism.

"The Exchange's approach to claims has been very aggressive and proactive, not at all passive," said Kelly, of Hinshaw, Culbertson, Moelmann, Hoban and Fuller. Kelly has been representing ISMIE policyholders since the establishment of the Exchange in July 1976.

"In non-physician-owned

companies, it is traditional to wait for the plaintiff to file a suit before any action is taken," Kelly said. But the Exchange works with physicians even earlier, encouraging them to report

*"These statistics  
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can buy."*

PHILLIP D. BOREN, M.D.

incidents as they occur and taking immediate action by interviewing the policyholder and discussing ways of preventing a suit from being filed. "That approach has remained pretty much the same through the years," he said.

The Exchange's relationship with its physician defendants and defense attorneys is another bonus for policyholders. In many companies, the only contact physicians have with their carriers and attorneys is during

the deposition process, he explained. "In the 1970s, the Exchange decided that wasn't good enough. Malpractice liability insurance is not the same as auto insurance. It takes a different approach."

The key to this difference is that claims against Exchange policyholders are reviewed by physician-policyholders who sit on the Physician Review Committee. The PRC works with the insured physician to help the Exchange decide whether to defend or settle a case.

"Traditional carriers not only hold the burden of satisfying stockholders, they have no access to physician review," Kelly said. The PRC is especially good at recognizing cases where a settlement offer should be made.

"In a few cases, the Exchange realizes that settlement can be a wise use of its resources," Dr. Boren said. "Understandably, physicians seldom want to give up on a case, but sometimes a prudent settlement is in the best

interest of the policyholder."

Most ISMIE cases never go to trial due to these early and aggressive techniques, Kelly said. Often the Exchange will file a motion for summary judgment, asking the court to determine if the suit is meritorious. Winning just one or two of these motions can save the Exchange a significant amount

of money down the line, he explained. "Winning a summary judgment is a much more economical approach. The best money spent on a suit is in the first year and the last six months before a trial," Kelly said.

"The Exchange tries to focus on making the first year as productive as possible." ■

## PIAA vs. Exchange payout percentages

The statistics below show the percentage of cases closed with indemnity of the Illinois State Medical Inter-Insurance Exchange as compared to those of the Physician Insurers Association of America. The PIAA is composed of physician-owned professional liability insurance companies that pool their claim data.

	PIAA	The Exchange
1986	34%	17%
1987	32%	13%
1988	32%	14%
1989	32%	18%
1990	32%	20%
June 1991	35%	21%

Source: the Physician Insurers Association of America and the Illinois State Medical Inter-Insurance Exchange.

## MALPRACTICE ROUNDUP

### Intoxicated patients

*Forum*, the publication of the Risk Management Foundation of the Harvard Medical Institutions Inc., advises physicians that they may need to take action to avoid liability risks if a seemingly intoxicated patient refuses care and insists on driving.

"When a patient appears incapable of using good judgment, intervention by a responsible person in the health care setting is justified," the newsletter reports.

Physicians may be able to detain such patients by offering to call a cab or a friend or relative. If treatment is required, *Forum* recommends waiting for sobriety, if possible. Under more drastic circumstances, such as instances when the patient presents a danger to him/herself or others, "The local police will place such a person in protective custody." ■

### Michigan health care task force hedges on tort reform

In Michigan, a health care task force recently released a report on health care reform that touched on medical liability issues. *Medigram*, the Michigan State Medical Society's weekly newsletter, reports that the House Democratic Task Force on Comprehensive Health Care included recommendations on pre-suit notification, a single defendant system in hospital liability suits and state reimbursement of physician liability insurance premiums based on the number of Medicaid patients a physician treats.

The report did not address limits on attorney contingency fees, caps on non-economic damages or a tightened statute of limitations,

(Continued on next page)

### ATTORNEY BOB BARON

addresses physicians at a presentation on medical and legal issues at the Will-Grundy County Medical Society's annual dinner. The May 20 presentation educated physicians on how to recognize sources of potential liability in their practices.



BOB McDONALD



# Attorneys, physicians praise defendant reimbursement policy

**LITIGATION:** The Exchange reimburses doctors for time away from their practice while defending malpractice suits. **By Anna Brown**

[ CHICAGO ] One year after the new service began, physicians and attorneys have found the Illinois State Medical Inter-Insurance Exchange's defendant reimbursement coverage a valuable aid in recovering income lost while defending malpractice suits. About 225 physicians have taken advantage of the program since its inception in July 1991.

"It takes courage and conviction to stand up for your rights when confront-

ed with malpractice claims," said Harold L. Jensen, M.D., chairman of the Exchange Board of Governors. "Your involvement as a defendant is essential to a successful defense. The defendant reimbursement program can help ease physicians' concerns about leaving their practices to defend themselves in court."

"The program is extremely well-received by physicians," said attorney Rudy Schade of Cassidy, Schade &

Gloor. "Time is money, and doctors greatly appreciate the reimbursement."

Physician defendants receive \$500 per day for time spent at depositions other than their own or at trials, and are eligible to be reimbursed up to \$5,000 per policy period.

"The Exchange instituted this service because we understand the enormous pressure of dealing with the legal system," Dr. Jensen said. "By assuring that

at least some income will be coming into the practice to cover costs, we can ease some of that pressure."

The Exchange wants to make more physicians aware of this service, Dr. Jensen said. Recently the Exchange mailed to defense attorneys a reprinted brochure from the "Cornerstone of Security" series detailing defendant reimbursement coverage. "We hope that by acquainting attorneys with the program they will encourage their clients to participate," he said.

"Most doctors are very interested in their own defense, but there is an economic factor involved," said William Rogers, a 17-year trial lawyer and partner with the firm Bollinger, Ruberry and Garvey. "Physicians don't say, 'I won't participate in my defense because I can't be away,' but they do tell me it's difficult to be away from the practice full-time."

"This program is helpful for physicians," Rogers continued. "Anything that helps my clients is good. It's a valuable thing to do."

The professional liability analyst documents the physician's attendance at depositions and the trial, and issues a check when the case is closed. Physicians are encouraged to contact their professional liability analyst to learn more about defendant reimbursement coverage. ■

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ISMS

## Malpractice Roundup

(Continued from page 9)

issues supported by the Michigan Medical Liability Reform Coalition and part of a Michigan House bill that failed by four votes to make it out of the House Judiciary Committee and onto the House floor this session. ■

## Attorneys not hurting

Attorneys' incomes are still rising, despite reports that they have been hurt by the recession, says *Medical Economics*. A survey by the Pennsylvania consulting firm Altman Weil Pensa found that annual pay increases for attorneys were 3 percent in 1990 and 3.7 percent in 1991. Median pay for partners in law firms was logged at \$151,000, as opposed to the median net income of physicians at \$141,720 (from the latest *Medical Economics* continuing survey in 1990).

The poll also found that in 1991 the average billing rate for partners was up 8 percent, at \$172 per hour. The average billing rate for associates remained at \$110 per hour. ■

## Crisis looming in Florida?

According to the *Miami Herald*, Florida's malpractice insurance rates are down, but insurance experts are predicting another crisis, perhaps within two years. Malpractice crises in Florida occur every eight to 10 years, the *Herald* reports. The last Florida crisis was in 1987, when skyrocketing insurance costs prompted some physicians to walk off the job. Before that, the last crisis occurred in 1975. ■



## EXCHANGE Q & A

For the past three years, Illinois Medicine has answered questions from policyholders in "Exchange Q & A." In this and future issues, we will republish the most frequently asked questions and answers. Physicians are encouraged to submit their inquiries to: Exchange Q & A, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

**Q: I will be leaving my practice for two months this summer. Will my policy cover a substitute physician who is not insured with the Exchange?**

**A:** Yes, for an additional premium. *Locum tenens* coverage is granted to a doctor not insured by the Exchange who is substituting for an ISMIE-insured physician.

This coverage can be granted under an endorsement in the Exchange physician's policy that adds the substitute doctor as an "additional insured." *Locum tenens* coverage is provided for

a maximum of 90 consecutive days.

The premium will depend on the number of substitution days and is computed as a direct percentage of the Exchange-insured physician's quarterly premium (for example, one to 15 days at 17 percent).

Applications for *locum tenens* coverage and additional information can be obtained by contacting the Exchange Underwriting Division at (312) 782-1654 or (800) 782-ISMS.

**Q: I intend to incorporate as a sole shareholder corporation. Do I need to apply for a corporate policy?**

**A:** No. A corporate policy is intended for a multishareholder corporation (two or more shareholders).

A corporation in which you are the only shareholder can be covered under your individual policy as an "additional name insured." In so doing, you and your corporation share the same limits of liability. There is no additional premium charge for this coverage. ■

## BuSpar® (buspirone HCl)

**References:** 1. Data on file, Bristol-Myers Squibb Company. 2. Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clonazepam in anxious outpatients with or without depressive symptoms. *Psychopharmacology*. 1992;25:10-21. 3. Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology*. 1989;21:124-130. 4. Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med*. 1987;82(suppl 5A):20-26. 5. Newton RE, Marunczyz JD, Alderdice MT, Napolitano MJ. Review of the side-effect profile of buspirone. *Am J Med*. 1986;80(suppl 38):17-21.

**Contraindications:** Hypersensitivity to buspirone hydrochloride.

**Warnings:** The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

**Precautions:** **General**—Interference with cognitive and motor performance: Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

**Potential for withdrawal reactions in sedative/hypnotic/anticholinergic drug dependent patients:** Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

**Possible concerns related to buspirone's binding to dopamine receptors:** Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

**Information for Patients**—Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

**Drug Interactions**—Concomitant use with other CNS active drugs should be approached with caution (see Warnings). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

**Pregnancy: Teratogenic Effects**—Pregnancy Category B: Should be used during pregnancy only if clearly needed.

**Nursing Mothers**—Administration to nursing women should be avoided if clinically possible.

**Pediatric Use**—The safety and effectiveness have not been determined in individuals below 18 years of age.

**Use in the Elderly**—No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

**Use in Patients with Impaired Hepatic or Renal Function**—Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

**Adverse Reactions (See also Precautions): Commonly Observed**—The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

**Associated with Discontinuation of Treatment**—The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

**Incidence in Controlled Clinical Trials**—Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: **Cardiovascular:** Tachycardia/palpitations 1%. **CNS:** Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. **EENT:** Blurred vision 2%. **Gastrointestinal:** Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. **Musculoskeletal:** Musculoskeletal aches/pains 1%. **Neurological:** Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. **Skin:** Skin rash 1%. **Miscellaneous:** Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

**Other Events Observed During the Entire Premarketing Evaluation**—The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. **Cardiovascular**—frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. **Central Nervous System**—frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. **EENT**—frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. **Endocrine**—rare: galactorrhea, thyroid abnormality. **Gastrointestinal**—infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. **Genitourinary**—infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. **Musculoskeletal**—infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. **Neurological**—infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. **Respiratory**—infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. **Sexual Function**—infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. **Skin**—infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. **Clinical Laboratory**—infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. **Miscellaneous**—infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

**Postintroduction Clinical Experience**—Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

**Drug Abuse and Dependence: Controlled Substance Class**—Not a controlled substance.

**Physical and Psychological Dependence**—Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

**Overdosage: Signs and Symptoms**—At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

**Recommended Overdosage Treatment**—General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.  
U.S. Patent Nos. 3,717,634 and 4,182,763

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**Now indicated for the relief of persistent anxiety with coexisting depressive symptoms.\***

▲ Anxiolytic efficacy demonstrated in anxious patients with or without coexisting depressive symptoms.<sup>2</sup>

▲ Relief of anxiety symptoms begins within 1 week, progresses steadily through the fourth week of therapy.<sup>3</sup>

▲ Nonaddictive, no more sedation (10%) than seen with placebo (9%).<sup>4,5</sup>

▲ The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

## Progressive Relief of Persistent Anxiety.

\*BuSpar is not indicated for the relief of primary depressive disorder.

Please see references and brief summary on adjacent page.

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# 1992 Legislative Issue

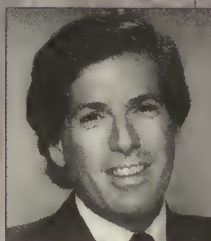
*Although 1992 was a relatively light legislative session because of the emphasis placed on budget negotiations and the state's fiscal crisis, Illinois lawmakers acted on a variety of health care measures. Among the session's highlights were the defeat of bills calling for a universal health care system and the passage of a measure limiting physician participation in executions.*

## Highlights of the General Assembly spring session

Issue	Outcome	ISMS position
Universal health	Failed	Opposed
Statewide universal health referendum	Failed	Opposed
Repeal physician witness requirement at executions	Passed	Supported
Practice by lay midwives	Failed	Opposed
Practice by clinical professional counselors	Passed	Opposed
Resident work hours	Passed	Supported
Medicare mandatory assignment	Failed	Opposed
Psychotropic drugs	Failed	Supported
Lead abatement	Passed	Supported
Healthy Moms/Healthy Kids	Passed	Supported
Self-referral	Passed	Bill reflects AMA ethical guidelines supported by ISMS



Governor Jim Edgar



William Marovitz



David Deets, M.D.



## PASSED

**Fibrocystic conditions** This Illinois State Medical Society-supported legislation mandates changes in the state's Insurance Code to ban limitations and exclusions in health insurance policies for women with fibrocystic conditions. Passed June 22, H.B. 2825 was sponsored by Sen. Jack Schaffer (R-Crystal Lake), House Minority Leader Lee A. Daniels (R-Elmhurst) and Rep. David Deets, M.D., (R-Dixon) the only physician lawmaker in Springfield.

**Mail-order pharmacies** An amendment added to S.B. 1749 creates regulation requirements for mail-order pharmacies under the state's Pharmacy Practice Act. The ISMS-supported measure parallels

House of Delegates policy calling for such regulation.

**AIDS testing of minors** H.B. 4056 grants immunity from civil or criminal penalties to health care providers for either notifying or failing to notify a minor

patient's parent or guardian about a positive HIV antibody test. However, the measure does require physicians and other providers to urge the child to talk to his or her parents or guardian before the doctor can contact the parents about the test result. Supported by ISMS, the bill was sponsored by Rep. Monique Davis (D-Chicago) and Sen. Smith.

**Women's health** Under a bill sent to Gov. Edgar June 19, the Illinois Department of Public Health must designate a staff member to handle women's health issues the department is currently not addressing. S.B. 1647 was sponsored by Sen. Smith and Rep. Trotter. ISMS supported the bill.

**Medicaid prompt payments** Four related measures sent to the governor June 18 amend the state's Prompt Payment Act by

calling for interest payments for medical providers who treat Medicaid patients and state employees and have to wait months for reimbursement. Introduced by Sens. Howard W. Carroll (D-Chicago), John J. Cullerton (D-Chicago) and Penny Sev-

erns (D-Decatur), and Reps. Bill Edley (D-Macomb) and Michael D. Curran (D-Springfield), S.B. 1588 and 1589 and H.B. 2697 and 3587 direct the comptroller to publish rules to enforce the Prompt Payment Act immediately. Currently, medical providers cannot collect under the Act unless they file separate claims for each patient and funds are available. Under the bills, the state would

pay late fees once the interest exceeds a certain amount, either \$25 or \$50, depending on the bill. The measures could cost the state as much as \$72.4 million in Medicaid late payments and \$11.4 million in interest charges from the state workers' health plan. But since no money is budgeted for these measures, the governor is expected to veto them.

**Prescription drug coverage** Passed June 11, S.B. 1533 prohibits all group health insurance policies and HMOs that cover prescription drugs for certain types of cancer from excluding use of these same drugs, if prescribed by a physician, for other types of cancer when the drugs have not yet received U.S. Food and Drug Administration approval for the "off-label" use. The ISMS-supported bill was sponsored by Sen. Severns and Rep. John F. Dunn (D-Decatur).

**Professional counselors** Sponsored by Sen. Emil Jones Jr. (D-Chicago) and Rep. Terry A. Steczo (D-Country Club Hills), S.B. 2056 was sent to Gov. Jim Edgar June 16. The bill allows the independent practice of clinical counselors, provided they meet state licensing requirements. The bill creates provisions similar to those in place under the state's Clinical Social Workers' Act. ISMS opposed the legislation, and Gov. Edgar vetoed a similar measure that passed the General Assembly last year.

**Naprapaths** S.B. 1468, sponsored by Sen. Jones and Rep. Daniel J. Burke (D-Chicago), establishes the Naprapathic Practice Act. Although ISMS opposed early drafts of the legislation calling for independent practice of naprapaths, the final version requires a physician, dentist or podiatrist referral and a documented current and relevant diagnosis. The bill, passed June 26, requires patients to remain under a physician's supervision while receiving treatment from a naprapath. A similar restriction applies to physical therapists.

**Alcoholism and drug dependency coverage** A bill on the governor's desk stipulates that health insurance policies that cover inpatient and outpatient alcoholism and drug dependency treatment cannot exclude coverage for any medically necessary services provided by "appropriately licensed providers." S.B. 1815 was sponsored by Rep. Terry R. Parke (R-Hoffman Estates) and Sen. Joyce Holmberg (D-Rockford). ISMS did not oppose the measure.

**Mammography standards** Sponsored by Sen. Smith and Rep. Barbara Flynn Currie (D-Chicago), this ISMS-supported measure requires the Illinois Department of Public Health to include American College of Radiology-recommended mammography standards in its breast cancer program summary. S.B. 1760 cleared the House June 11.

## FAILED

**Birthing/recovery centers** A lack of consensus on how to establish pilot projects for birthing and recovery centers doomed these centers for this year. Although a task force on acute care appointed by Gov. Edgar had developed guidelines to implement the programs, the General Assembly instead adopted a conference committee report of a bill that

allows the start-up of subacute care centers to fill access gaps for patients who need services between those offered by hospitals and long-term care facilities. ISMS was represented on the acute care task force.

**Utilization review** A bill aimed at regulating utilization review entities did not emerge from committee. Sponsored by Rep. Al Ronan (D-Chicago), H.B. 3930 was supported by ISMS, but negotiations with the insurance industry and business groups failed to yield an acceptable compromise consistent with ISMS policy.

**Psychotropic drugs** A measure remained in committee that would remove requirements that physicians give patients written information about the side effects and risks and benefits of psychotropic drugs. Sponsored by Sen. Jack Schaffer (R-Crystal Lake), S.B. 2143 was supported by ISMS.

**Billing irregularities** H.B. 2810 would

have authorized disciplinary action against physicians and other providers for so-called irregularities in bills submitted to third party payers. Sponsored by Rep. Margaret R. Parcels (R-Glenview), the bill did not advance out of committee. ISMS opposed the measure.

**Medical practice exemptions** Sponsored by Rep. David R. Leitch (R-Peoria), H.B. 3685 would have granted immunity from civil damages to physicians, hospitals or other health care facilities who treat indigent patients referred from a free clinic. The ISMS-supported measure failed to advance out of committee.

## TABLED

**Universal health vehicles** Two bills eyed as vehicles to advance proposed universal health care legislation failed. S.B. 1645 was tabled in the Senate June 25, and H.B. 3395 was never called for a vote because the necessary votes needed for passage could not be garnered, insiders say. Earlier in the session, the original bills creating a state-run, single-payer health care delivery system for Illinois failed to pass out of their houses of origin. ISMS opposed the measures.

**Elderly abuse reporting** S.B. 2107 set forth requirements mandating that health care professionals report any suspected or alleged instances of abuse or neglect of elderly patients. The bill, sponsored by Sen. Earlean Collins (D-Oak Park) and Rep. Clem Balanoff (D-Chicago), was tabled in the House June 11. ISMS opposed mandatory reporting provisions in the bill.

**Attorney malpractice immunity** A bill attempting to provide immunity to attorneys from legal malpractice actions in

(Continued on page 14)

## Passed

**Lead abatement** Building on last year's legislation mandating lead screening of school children, the General Assembly June 26 passed a lead abatement measure. The bill parallels 1992 ISMS House of Delegates policy. Rep. Ann Stepan (D-Chicago) and Sen. John J. Cullerton (D-Chicago) sponsored the measure.

## Failed

**Lay midwives** A second attempt to establish licensing criteria for lay midwives failed July 1. First defeated in committee in May, H.B. 3521 would have allowed the independent practice of lay midwives. At the end of the session, supporters tried a last-ditch effort to revive the bill as a resolution that would have created a task force to implement licensing standards. ISMS opposed the measure.

## Passed

**Resident work hours** Passed June 26, S.B. 1692 addresses regulation of resident and intern work hours. ISMS supported the amended measure, which requires all Illinois-licensed hospitals to meet Accreditation Council for Graduate Medical Education standards for resident and intern work hours. The bill was sponsored by Sen. Margaret Smith (D-Chicago) and Rep. Donne E. Trotter (D-Chicago).



# Lawmakers endorse self-referral ban

**SELF-REFERRAL:** The General Assembly passed legislation banning patient referrals to facilities that health care professionals own but at which they do not treat patients. **By Tamara Strom**

[ SPRINGFIELD ] After weeks of fierce lobbying and intense negotiation, Illinois lawmakers July 1 passed legislation banning many health care self-referral practices. For physicians, the most important aspect of the legislation is that the ban does not extend to patient referrals made to facilities where doctors themselves treat the referred patients,

regardless of their financial interest. The bill also does not prohibit referrals to other physicians within a group practice.

As passed, the Health Care Worker Self-Referral Act applies not only to physicians but to all Illinois-licensed health care workers such as dentists, nurses, clinical psychologists, social workers, pharmacists, physical thera-

pists, podiatrists and optometrists. The legislation mirrors the American Medical Association's ethical report on self-referral; that report, like the Illinois measure, states that physicians should refrain from referring patients to facilities they own but at which they do not treat patients. The self-referral bill was sponsored by Sen. William A. Marovitz (D-Chicago).

And while the AMA report was meant to be used as an ethical standard for physicians, not a legislative blueprint for lawmakers, the guidelines did serve as a

reasonable basis for the bill ultimately passed in Springfield this month, said Illinois State Medical Society President Arvind K. Goyal, M.D.

"It's important to point out that this bill is preventive in nature. Even those referrals that currently occur and that would be prohibited under the Act may not be inappropriate," Dr. Goyal told *Illinois Medicine*. "We don't perceive any current problem with referral abuses in Illinois. But this legislation, which would significantly impact the availability

and provision of health care services, was introduced and was advancing before ISMS got involved. This is not a bill the medical society sought in Springfield, but it was sought by the Illinois chapter of the American College of Radiologists. ISMS worked hard to assure that its provisions include a fair and reasonable approach to regulating self-referrals. It's a difficult issue."

Dr. Goyal cited the key role to be played by the Illinois Health Facilities Planning Board in writing rules to implement the legislation and determining referrals that are appropriate under the Act. Physicians can ask the board for advisory rulings to determine if current or proposed referral arrangements are permissible under the bill's provisions; if the referrals are prohibited, the planning board must respond within 90 days.

"The bill gives the planning board the flexibility to apply the law in a fair and objective manner," Dr. Goyal said.

For example, the planning board holds responsibility for determining the appropriateness of self-referrals to physician-owned facilities in communities where a "demonstrated need" exists and alternate funding for the facilities is not available, Dr. Goyal said. "Often physicians or other health care workers are the only community residents with the necessary knowledge, interest and resources to build and maintain needed health facilities," he noted. "In such areas of the state, the loss of the facilities would enlarge access gaps for community residents. As written, the bill enables the planning board to allow these necessary referrals on a case-by-case basis."

Under the legislation, if a facility has been declared exempt from the ban,

health care workers must also disclose to patients their financial interest in the referral facility. And if other facilities offering the same services are available in the community, the physician must offer the patient a choice between facilities. "Disclosing financial interest to patients will help avoid any perceptions of impropriety," Dr. Goyal said. "But if physicians are in compliance with the bill's provisions — as we expect they will be — disclosure is only an additional safeguard."

The referral ban does not extend to facilities

owned by companies publicly traded on the open market, such as the New York Stock Exchange, with assets of more than \$30 million. However, even in these large facilities, the bill states that a physician's income from the investment cannot be tied to the number of referrals a doctor makes and the health care provider cannot own more than .5 percent of the total equity.

Although the bill specifically bans many referrals for health care services, it does not apply to referrals for "goods." For example, physicians can refer patients to purchase medical supplies or appliances at facilities they own.

Violating the referral ban could result in civil monetary penalties of up to \$20,000 for each illegal referral for a facility and is considered grounds for disciplinary action.

*"ISMS worked hard to assure that its provisions include a fair and reasonable approach to regulating self-referrals. It's a difficult issue."*

ARVIND K. GOYAL, M.D.

## YOCON® YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

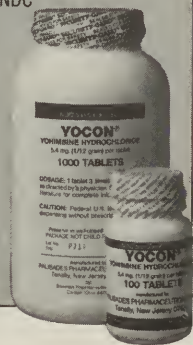
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## Legislative highlights

(Continued from page 13)

cases where an insurer fails to make periodic payments established in structured judgments was tabled June 26. Sponsored by Sen. David Barkhausen (R-Lake Forest) and Rep. David B. McAfee (D-Indian Head Park), S.B. 2134 was opposed by ISMS.

**Mandatory assignment** An effort to prohibit physicians treating Medicare patients from charging or collecting fees above the U.S. Department of Health and Human Services-set charges was derailed in committee.

ISMS opposed the bill, which was sponsored by Rep. Jan Schakowsky (D-Evanston).

**Tuberculosis testing** A bill that would have made TB screening tests a routine element in medical examinations for school children was referred to the Senate Rules Committee. The bill, sponsored by Rep. Balanoff, was passed by the House. A similar bill, sponsored by Sen. Judy Baar Topinka (R-Berwyn), also failed to advance in the Senate. ISMS supported both measures.

— By Tamara Strom



# Physicians not required to witness executions; confidentiality remains

**LETHAL INJECTION:** Under legislation adopted by the General Assembly, two physician witnesses are no longer required at state-ordered executions. **By Tamara Strom**

[ SPRINGFIELD ] Two physicians will no longer be required to serve as witnesses at state-ordered executions anymore, but a doctor will still have to pronounce death of the executed inmate, according to legislation passed by Illinois lawmakers this session. The Illinois State Medical Society-supported legislation was passed as a compromise measure and was amended to a vehicle bill as the session closed. Under the measure, only six witnesses – who need not be physicians – instead of the current eight, will be required at future executions.

**A BILL REMOVING THE PHYSICIAN** witness and pronouncement of death provisions from the Illinois Criminal Code passed the House in the first half of the session but stalled in the Senate. Legislators, including House sponsor Rep. Thomas J. Homer (D-Canton), balked at attempts to amend the bill by eliminating confidentiality safeguards for individuals, including physicians, who participate in executions. Because the deadline for introduction of bills this session fell after the ISMS annual meeting, the original version did not include language eliminating confidentiality for physicians and other participants. That language would have brought state law in line with ISMS policy that was adopted at the April 1992 meeting.

*Bill opponents disagree with ISMS that doctors violate medical ethics when making a post-execution pronouncement of death.*

Sen. Robert M. Raica (R-Chicago) withdrew his sponsorship of the bill after ISMS began pressing for repeal of current confidentiality language. The Illinois Department of Corrections, the Illinois attorney general's office and several state's attorneys also fought the confidentiality amendment and the elimination of doctors' declaring death, calling those changes "a back-door attempt to abolish the Illinois death penalty law." Legislators and attorney general's office officials said they viewed these provisions as an attack on the death penalty, not a protection for physicians.

"The opponents of [the bill] disagree with the Illinois State Medical Society that a doctor violates medical ethics when he or she makes a post-execution pronouncement of death," according to a letter to the Society from the attorney general's office. "We would agree if the law required a doctor to administer the lethal injection. But the law only requires a doctor to perform a function which he or she regularly performs in the course of medical practice. Examining and pronouncing a person dead is a doctor's responsibility whether the event leading to an individual's death was a stroke,

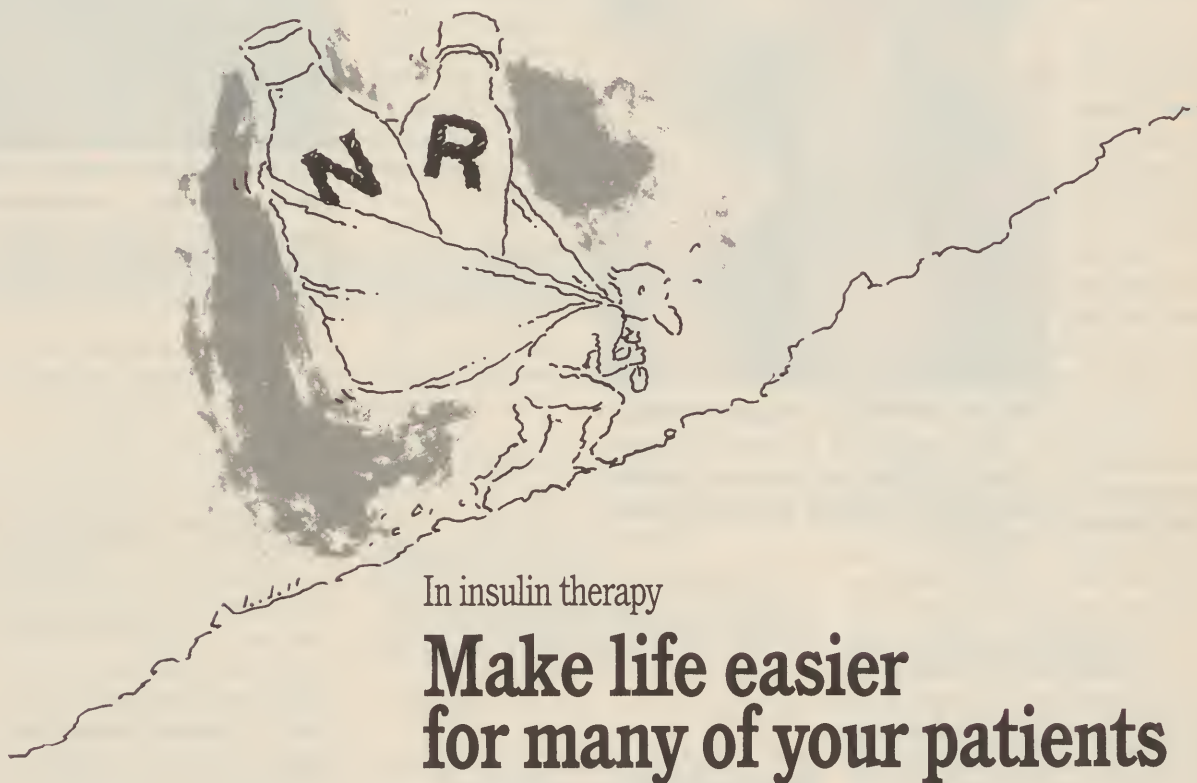
accident, wound or a legal execution."

The original version of the bill eliminated responsibility for pronouncing death from physicians. Instead, the bill spelled out that following the execution, the coroner would be notified and "order appropriate action." However, the attorney general's office expressed concern that in counties such as Will County, where Stateville Penitentiary is located, the coroner is not a physician.

Having non-physicians declare death could lead to claims by defense attorneys that the person might be erroneously declared dead, making the Illinois death penalty cruel and unusual punishment, and therefore unconstitutional. The unintended result could be delays in executions for such notorious Death Row inmates as John Wayne Gacy and Henry Brisbon, according to the attorney general's office.

"Only a licensed doctor is qualified by training and experience to determine when an individual's heart and brain functions have stopped and death has in fact occurred," the attorney general's communique added.

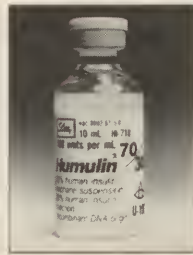
Any further attempts to ban confidentiality for physician participants in state-ordered executions or lift the declaration of death requirements must wait until at least the fall veto session. ■



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# AMA delegates focus on ethical issues at annual meeting

**PHYSICIAN DEBATE:** Delegates give the nod to several Illinois resolutions as they tackle issues ranging from self-referral and indigent care to RBRVS and public health issues. **By Anna Brown, Rachel Brown, Kathy Meyer, Kevin O'Brien and Tamara Strom**

## Self-referral and indigent care issues take center stage in the House

Two issues regarding ethics – physician self-referral and caring for the poor – took center stage at the AMA annual meeting.

The House of Delegates reverted to a 1986 position on self-referral when it declared physicians may ethically refer patients to labs in which the doctor has a financial interest, as long as the potential conflict of interest and the names of alternate facilities are disclosed to the patient.

The new policy appears to be in direct contradiction to a report of the Council on Ethical and Judicial Affairs adopted by the House six months ago and clarified by the council in May, saying that physicians should not refer patients to such facilities. That report serves as the basis for the Illinois State Medical Society position on self-referral legislation that was passed in Springfield.

Delegates were sharply divided on the issue, and the reference committee recommended referring the report back to the council for reconsideration. Delegates favoring a New Jersey resolution to lift the ban, however, argued that AMA policy should be targeted only to physicians who over-refer, not to all those who own or have an interest in labs and other facilities.

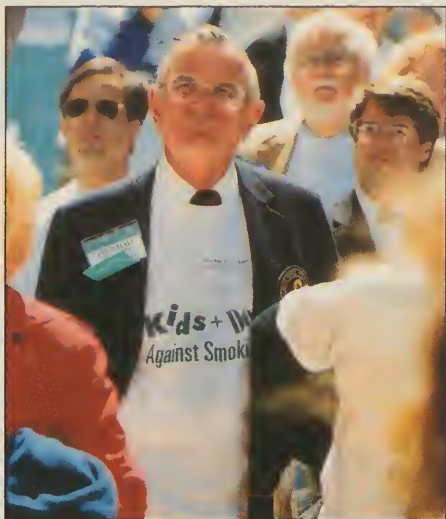
On a 216-210 vote, delegates voted to send back to the Council on Ethical and Judicial Affairs its Report D: "Caring for the Poor." The report stated, "individual physicians have an [ethical] obligation to help care for the indigent," and offered guidelines to determine the amount of free care doctors should provide.

Although testimony and debate universally supported the concept of providing indigent care, many delegates cautioned that the word "ethics" has legal implications in many states, including Illinois.

The razor-close vote caused a flurry of press reports implying, delegates later said, that the House had voted against caring for the poor. Delegates the next day adopted an emergency resolution reaffirming physicians' "moral obligation and commitment ... to care for the poor."

## Administrative costs and public education efforts

Tired of being targeted as a major cause of rising health care costs, physicians lashed out during the meeting, calling for fairness in assessing responsibility for reining in costs. The House of Delegates adopted a substitute version of an Illi-



Illinois alternate delegate William J. Marshall, M.D., of Olympia Fields, listens to speeches during the AMA's protest of the tobacco industry.

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New American College of Surgeons delegate George E. Block, M.D., (third from left) was welcomed to Illinois by ISMS President Arvind K. Goyal, M.D.; AMA Trustee P. John Seward, M.D.; and ISMS Board Chairman Jere E. Freidheim, M.D.

WM. DANIELS/THE PHOTO PARTNERS

nois resolution endorsing limits on "excessive costs" of non-physician health care providers.

The policy directs the AMA to study the issue of rising costs in non-M.D. areas of health care delivery and disseminate the findings to federal and state policy makers for use in deliberations on various health care reform proposals.

Two related Illinois-sponsored resolutions were adopted by the House. Delegates endorsed Illinois' call for the AMA to develop a broad-based public information program, including an educational brochure for distribution in physician offices that compares different health care reform proposals. Delegates also adopted an Illinois measure directing the AMA to be a more forceful and effective voice on national health care issues. The AMA should be a visible player in national debates on such topics as health care delivery and pharmaceutical and insurance industry issues, delegates said.

## Illinois again proposes dismantling Data Bank

For the second consecutive year, the Illinois delegation to the AMA proposed dismantling the National Practitioner Data Bank in the House of Delegates. The delegation submitted an amendment to a Board of Trustees report that would have stiffened the AMA's resolve to abolish the Data Bank.

Although the Illinois amendment was defeated, heated floor debate generated considerable support for Illinois' position. Several delegations – including an Oklahoma delegate who called the Data Bank a "computer full of cow chips" – said they share Illinois' concerns about the Data Bank but advocated a slower, more cautious approach.

Chester C. Danehower Jr., M.D., alternate delegate from Peoria who introduced the Illinois amendment, said he is "disappointed" the House failed to adopt the measure but added that he understands the need for flexibility in trying to effect changes in the Data Bank. "Illinois has not changed its mind about the Data Bank," Dr. Danehower told the House. "We still feel the Data Bank should be abolished. It's an insult to every physician in this country. It's an abomination and it's un-American."

"We meant it last year and we mean it this year; the Data Bank cannot be improved," said Illinois delegate Albino T. Bismonte Jr., M.D., during floor debate.

## HIV disability resolutions

Three resolutions calling for the AMA to work with insurance companies to develop disability insurance for HIV-positive physicians without symptoms were referred to the Board of Trustees.

Although delegates supported the intent of all three resolutions, some believed that the resolutions, introduced by the Missouri delegation and by the Texas delegation, were too narrow in



**THE AMA CITED SEVERAL ILLINOIS PHYSICIANS** for their membership recruitment efforts. In photo at left: Immediate Past AMA Chairman Joseph T. Painter, M.D., of Houston, congratulates Illinois physicians who recruited new AMA members through the Hospital Medical Staff Section Outreach Program. Pictured are, from left: Dr. Painter; Ronald D. Frus, M.D.; Maynard I. Shapiro, M.D.; Gail D. Williamson, M.D.; Dennis M. Brown, M.D.; and Joseph L. Murphy, M.D. Not pictured are Donald H. Buser, M.D.; Donald W. Edwards, M.D.; and Jerome J. Frankel, M.D. In photo at right: Honored for their recruitment efforts through the House of Delegates Outreach Program were (clockwise from left): Albino T. Bismonte Jr., M.D.; Joseph B. Perez, M.D.; Arvind K. Goyal, M.D.; Ronald G. Welch, M.D.; Silvana Y. Menendez, M.D.; and Arizona delegate Neopito Robles, M.D. Also honored from Illinois was Clair M. Callan, M.D. (not pictured).

AMERICAN MEDICAL ASSOCIATION

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scope. These resolutions called for the AMA's immediate action in working with insurance companies to develop disability policies. An Illinois resolution asked that the AMA study this issue, with the understanding that HIV-positive physicians may lose patients or be prevented from performing duties vital to their practices. ■

## Medical malpractice resolutions adopted

Two Illinois resolutions affecting malpractice received favorable action.

A resolution directing the AMA to support introduction of federal legislation requiring caps on non-economic damages in malpractice awards as an "integral and necessary part of any [national] health care policy reform plan" was adopted on the House consent calendar.

**Delegates adopted** without debate a substitute resolution encouraging physicians, "as a matter of public interest," to serve as impartial expert witnesses in medical malpractice trials.

The original Illinois-sponsored resolution sought to make such service a physician's "obligation." The original resolution also stipulated that such service constituted the practice of medicine and that physician witnesses' opinions in such cases be based on a knowledge and understanding of the facts of the case and on "science, truth, honesty, personal and professional experience." ■

## AMA as collective negotiating authority

The House of Delegates declared achieving the ability to negotiate collectively issues relating to reform of the U.S. health care delivery system the AMA's "highest of priorities."

Viewed by many delegates as a new "proactive" direction for the AMA, the House action instructed the Board of Trustees to seek establishment of "formal physician involvement in all areas of public and private sector health care policy development and implementation." These areas include, but are not limited to, review of quality and appropriateness of care, appropriateness of payments and fees, negotiation of reimbursement, and predictability of health care costs. ■

## Physicians assail RBRVS

Having labored under the RBRVS Medicare payment reform system for seven months, AMA delegates adopted policy to correct flaws in the reimbursement mechanisms.

Although 12 resolutions and a Board of Trustees report were introduced dealing with RBRVS, reference committee efforts and floor debate combined 11 of the measures into a single, comprehensive policy statement. The House also adopted a substitute resolution directing the AMA to oppose expansion of RBRVS to private payers until the system's inequities can be eradicated.

Delegates endorsed eliminating reduced payments for new physicians and adding reimbursement for interpreting EKGs. Delegates also directed the AMA to assure that Medicare reim-



Arthur R. Traugott, M.D., (right) and Edward J. Fesco, M.D., members of the Illinois delegation, testify on the House floor.

bursements will be altered as physicians' costs increase due to state and federal regulations. Delegates cited rising practice costs associated with the Clinical Laboratory Improvement Amendments and U.S. Occupational Safety and Health Administration mandates on infection control and bloodborne

pathogens as examples of regulations impacting health care costs.

The House also took aim at Medicare and other third party payers' inequitable payment policies for primary care physicians and specialists who treat patients concurrently. Delegates blasted payers' current policies to deny all claims except the "first one in" for services provided to the same patient by different physicians. Delegates voted down an Illinois-sponsored resolution calling for the AMA to investigate a \$33 million contract awarded by the U.S. Health Care Financing Administration to conduct a Medicare beneficiary survey, saying the intent of the resolution was included in a Council on Medical Service report the House adopted. ■

## Anti-tobacco sentiment

After joining U.S. Surgeon General Antonia Novello, M.D., marching down Michigan Avenue to protest RJ Reynolds' "Old Joe Camel" ad campaign June 21, delegates strengthened the AMA's crusade against smoking. Pointing to the recent U.S. Supreme



Immediate Past AMA President John J. Ring, M.D., of Mundelein, addresses the House of Delegates for the last time as president of the "new AMA."

Court ruling permitting smokers who develop lung cancer to sue tobacco companies as "another nail in the coffin of 'Old Joe Camel,'" AMA Trustee Lonnie Bristow, M.D., said, "The American Medical Association will not stop until tobacco is gone."

Alarmed by increasing evidence of the harmful effects of passive smoke, the House directed the AMA to seek a universal ban on smoking in the workplace. This came following reference committee debate over establishing a minimum standard for allowable levels of passive smoke. The resounding sentiment among delegates was that the "standard should be zero" to fully protect non-smokers' health. ■

## Use of illegal drugs

Adopting an ISMS-sponsored resolution, the AMA reaffirmed its opposition to the dissemination and use of illegal drugs. "Current AMA policy addresses specific drugs. We wanted to broaden that to include any illegal use of drugs. And this would encourage physicians to work within their communities to discourage illegal drug use," said Joan E. Cummings, M.D., an Illinois delegate. The new policy condemns illegal drug use of any kind. ■

## Lead screening for children

Recognizing the need for adequate funding of public health programs, the House adopted a resolution urging federal agencies to suspend their screening recommendations for children pending further evaluation of lead abatement programs and their appropriateness. ■

## Medical waste disposal

In light of the recent tightening of government regulation of medical waste disposal, the delegates also agreed to seek a more rational definition of contaminated medical waste and policy for disposal of that waste. The current definition of medical waste includes such common items as alcohol swabs, tongue depressors, bandages and diapers. Delegates also expressed their fear that increased "government regulations [would] only bring about high financial costs," not increased public safety. ■

### ILLINOIS RESOLUTIONS SCORECARD

	Resolution	Outcome
4	Psychiatric treatment as a prerequisite for capital punishment	Referred to Board of Trustees
110	Non-physician cost containment	Substitute Res. 110 adopted
125	Administrative costs of HCFA	Board of Trustees Report EE adopted in lieu of Res. 125
130	Medical survey	Council on Medical Services Report E adopted in lieu of Res. 130
131	Organized medicine's views on national issues	Adopted
136	Public information program	Referred to Board of Trustees
218	AMA policy, titled "Governmental Medical Educational Loans"	Adopted
221	Health Assurance Act of 1992-1993	Not adopted
222	Filling the physician gap in times of national emergencies	Referred to Board of Trustees
223	Expert witness testimony	Substitute Res. 223 adopted
224	Federal legislation and policy	Substitute Res. 224 adopted
225	Medicare fund tax on tobacco and alcohol products	Adopted
226	Malpractice reform linkage with public health policy reforms	Adopted
227	Mammography	Not adopted
405	Clarification of the definition of disability for HIV-positive physicians	Referred to Board of Trustees
417	Eating disorders	Adopted
523	Policy on illegal drug use	Adopted as amended
605	Violent acts against physicians	Adopted as amended
704	Regulations on claims review	Adopted
808	Hospital charges	Referred to Board of Trustees
809	CPT coding system	Substitute Res. 809 adopted
811	Hospital and office overhead expense	Referred to Board of Trustees



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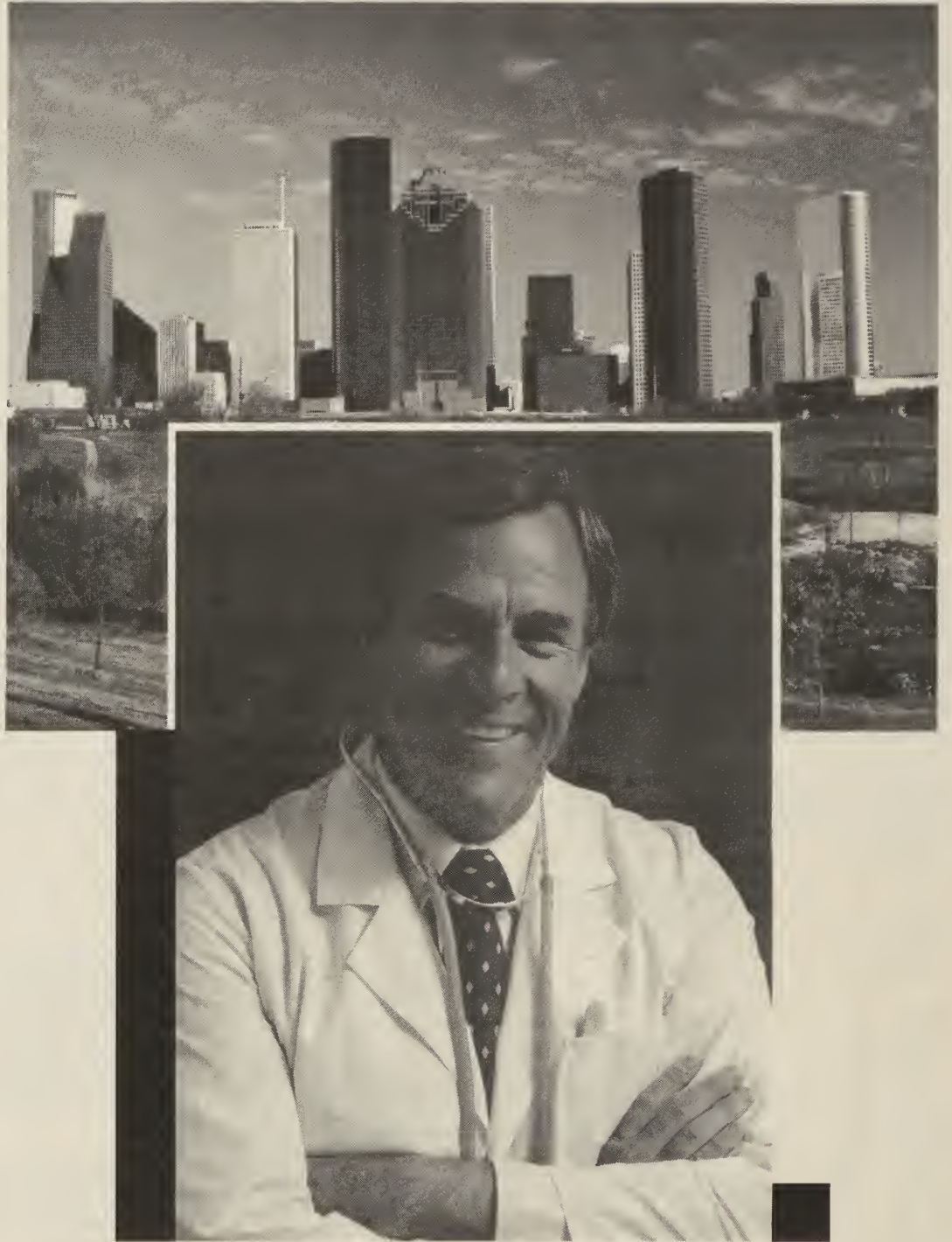
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## Legislators end session

(Continued from page 1)

tively solid bottom lines will pay more money into the Medicaid system than they will be reimbursed. According to Illinois Department of Public Aid figures, only those hospitals whose patient mix is less than 4 percent to 5 percent Medicaid would lose under the program; more than 80 percent of the state's hospitals would benefit from the redistributive assessments. The assessment program is necessary to capture federal matching funds. Without the plan, Illinois' Medicaid budget faced a \$735 million budget gap. The program does not

affect physician reimbursement.

Also included in the last-minute budget awaiting Edgar's pen are changes in the Medicaid appropriation that impact physician reimbursement. Overall, the physician line for Medicaid rises more than 8.5 percent in fiscal 1993. And while the total funds appropriated for reimbursement increase, some physicians will see their Medicaid patients lose coverage, as 60,000 single adults on transitional assistance were severed from the Medicaid rolls July 1.

Quicker and higher reimbursement should result when IDPA implements its new managed care program, "Healthy Moms/Healthy Kids." Phase-in of the


\$19 million program begins Jan. 1, 1993. Under the plan, physicians who treat pregnant women, new mothers and their children within the confines of the program's managed care protocols will see higher reimbursement rates. IDPA hopes the case management aspects of the proposal will maintain patients in the health care system, keeping them from needing more expensive care from hospital emergency rooms when their conditions become serious. Details of the plan are still being finalized.

Physicians who treat state workers can expect continued delays in reimbursement due to the budget compromise. Lawmakers appropriated about \$25 million less

than the governor had requested for the state employees' health plan. The plan was severely underfunded this year, and some of the fiscal 1993 appropriation must be used to pay doctors for care they delivered before fiscal 1992 ended June 30.

And while budget negotiations dominated the legislative session, lawmakers also found time to act on several other health care-related measures, including self-referral limitations, elimination of physician witness requirements for state-ordered executions and lead abatement mandates.

For more coverage of these and other health care-related measures, see *Illinois Medicine's* legislative wrap-up section. ■

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## Media outreach

(Continued from page 1)

tured Dr. Goyal introducing the ISMS principles of health care reform and pointing out how the universal health plan failed to measure up to them.

Following the press conference, Dr. Goyal and district trustee Jane Jackman, M.D., met with the editor of Springfield's *State Journal-Register* to review the universal health bill and health care reform efforts. Even before the press conference Dr. Goyal called on editors at *Crain's Chicago Business* and the *Chicago Tribune* to lobby for editorial support opposing universal health.

An intense schedule of editorial briefings at newspapers across the state followed: Trustee Ronald Welch, M.D., of Belleville, visited editorial staff at the *St. Louis Post-Dispatch* on May 14, while

President-elect Arthur R. Traugott, M.D., and trustee Ronald L. Ruecker, M.D., briefed the editorial board of the *Decatur Herald & Review* on May 19.

Robert M. Reardon, M.D., immediate past president, led a team of state and county medical society representatives in a briefing with editors of the *Peoria Journal-Star*; Dr. Reardon also visited with the Bloomington *Pantagraph* editorial leadership in May.

In his hometown of Champaign, Dr. Traugott briefed the editor of the *Champaign News-Gazette*.

Newspapers in the Quad Cities, including the *Quad City Times*, Rock Island *Argus* and Moline *Daily Dispatch*, were briefed by trustee Richard Snodgrass, M.D., and county and state representatives. The briefing resulted in a favorable editorial in the Moline *Daily Dispatch*.

The *Chicago Sun-Times* editorial board and the editors of suburban Pad-dock Publications group, which publishes the *Daily Herald*, also received visits from Dr. Goyal. In Winnebago County, district trustee William Kobler, M.D., met with the editorial boards of the *Rockford Register-Star* and the *Freeport Journal*, while area physician Anthony Molinari, M.D., carried the ISMS message to the *Belvidere Republican*.

In addition to the editorial board briefings, ISMS distributed a guest editorial titled, "Universal Health: A Prescription for Disaster" to every newspaper in the state. Written over Dr. Goyal's byline, the editorial has been published in more than 65 newspapers across the state, from the *Chicago Tribune*, with its circulation of almost three-quarters of a million, to the *Oakbrook Terrace Press*, which claims 326 readers.

Efforts devoted to public education were under way at the same time. The handout included in this issue of *Illinois Medicine* can be used by physicians to educate legislators, patients, office staff—any party with an interest and stake in health care reform.

Post cards provided to physicians for patients to mail to legislators announced: "I agree with my doctor. A government-run health care system would be bad for Illinois."

While the enabling legislation may be dead in the General Assembly for this session, Society efforts to educate the public and to take a highly visible leadership position on health care reform in Illinois will continue. Watch for further stories in *Illinois Medicine*. ■

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## Universal health

(Continued from page 4)

11 percent to payroll taxes.

Although neither chamber took substantive action addressing the state's growing health care access and affordability problems, achieving health care reform of some kind will remain high on legislators' agendas next year, observers note. There is mounting concern in all quarters — from those who support a single-payer system to those who want to build on the strengths of the current system — that legislative remedies are needed to correct deficiencies in the present delivery system. This point was punctuated this session by the fact that the costly universal plan received 54 votes in the House. Some lawmakers voted for the proposal because it was the only plan introduced this year, and they did not want to return to their districts saying they didn't address their constituents' concern on this issue, observers added.

**Also killed this session** were bills calling for a statewide referendum in November on universal health care. H.B. 3687, sponsored by Rep. Jan Schakowsky (D-Evanston), and S. B. 2117, introduced by Sen. Vincent Demuzio (D-Carlinville), would have added an advisory question to the November ballot urging Congress and President Bush to move forward on universal health at the national level. Both bills were being pushed by Illinois Treasurer Patrick Quinn; neither measure passed in committee.

In May, a coalition supporting a Canadian-style health care system here in Illinois demonstrated at the Capitol and in front of the Society's Springfield offices, claiming ISMS was blocking health care reform. Dr. Goyal disputes those claims, pointing to the Society's adoption of 10 principles of health care reform against which reform proposals can be measured. A single-payer, tax-funded system, he said, does not match up to the Society's principles.

"It promises everything to everyone," Dr. Goyal said. "In reality, the state cannot afford a program such as this. Ultimately, a single-payer, state-run system will result in universal rationing as the state finds itself unable to afford what it promises. We will continue to work to educate legislators, the public and our patients in this regard and provide input in fixing the current health care system so our patients truly benefit." ■

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**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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ABORTION  
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Illinois  
Medicine

ILLINOIS STATE MEDICAL SOCIETY • JULY 31 1992

MEDICAL COLLEGE  
OF WISCONSIN  
AUG 1 1992The Bataan  
Death March:  
One physician  
remembers

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HHS continues  
DME crackdown

**DME:** Physicians must exercise caution to assure medical necessity for durable medical equipment for government-paid patients. By Tamara Strom

[ CHICAGO ] In conjunction with its other anti-fraud efforts, the federal government is continuing its crackdown on payments for non-medically necessary durable medical equipment. Although many physicians unwittingly approve such equipment for their patients, the burden of liability for certifying that the patient actually

needs the device rests solely with the doctor.

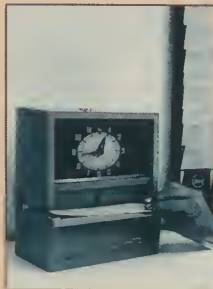
"Physicians must be careful about what they are signing," said Michael T. Dyer, regional inspector general for the U.S. Department of Health and Human Services. "They must assure that a medical necessity exists for the equipment and

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## I N S I D E

**ADA requires**  
changes in physician-  
employee relations

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**AMA tackles**  
public health issues

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OIG, FBI pharmacy fraud  
investigations show results

**FRAUD:** Stepped-up investigations by the U.S. Office of Inspector General and FBI are resulting in indictments for health care fraud. By Tamara Strom

[ CHICAGO ] Claiming fraud is bilking the U.S. health care system out of billions of dollars a year, the federal government anti-fraud investigations are yielding results. The latest casualties in the government's war on fraud are 13 Illi-

nois pharmacists indicted last month under the joint FBI-OIG "Operation Goldpill" investigation. Joining the FBI and OIG in the investigation were the U.S. Drug Enforcement Agency, the Food and Drug Administra-

(Continued on page 21)

## ISMS BEHIND THE SCENES

ILLINOIS PHYSICIANS REPRESENT  
THEIR COLLEAGUES AT THE AMA

By Kevin O'Brien

[ CHICAGO ] An observer of the American Medical Association's House of Delegates' recently concluded annual meeting in Chicago might have noticed that the Illinois delegation was one of the quieter delegations during much of this year's floor debate.

But that quiet belies the delegation's effectiveness: Witness its record. Illinois introduced 22 resolutions for consideration by this year's House; of these, nine were adopted or adopted as amended, four had a substitute resolution adopted, five were referred to the Board of Trustees, and two had board reports adopted in place of the resolutions.

Only two were not adopted.

"The Illinois delegation brought before the AMA House a number of important issues," said AMA Trustee P. John Seward, M.D., a family physician from Rockford. He noted that the delegation's influence helped shape resolutions dealing with such major issues as health care reform, the National Practitioner Data Bank and physician participation in capital punishment.

Preparation is key to the delegation's exercising that influence. Many Illinois delegates point to the exclusive Illinois State

(Continued on page 18)



Abortion services were authorized at Cook County Hospital through an executive order issued by Cook County Board President Richard J. Phelan.

Cook County scheduled to  
resume abortions July 30

**ABORTION:** Despite a procedural maneuver to delay implementation, Cook County Hospital was scheduled to resume abortions. By Kevin O'Brien

[ CHICAGO ] Thursday, July 30, was the scheduled day.

That's the day abortions were scheduled to resume at Cook County Hospital after nearly a 12-year hiatus. Fulfilling a campaign pledge made two years ago, Cook County Board President Richard J. Phelan June 18 signed an executive order reinstating the procedure his predecessor banned in 1980.

Abortion opponents on the county board have maintained that Phelan lacks the authority to act unilaterally. They argued that when former board President George Dunne issued his executive order banning abortions, the board "ratified" his decision. Thus, they said, only the board can order the hospital to reinstate abortion.

Phelan, however, said in his executive order that although the board concurred with Dunne's action, it "failed to pass any ordinance ratifying the action of the former presi-

dent," and that "concurrence of the board" with Dunne's action is not binding on Phelan.

This issue was seemingly put to rest July 7 when some anti-abortion commissioners failed in their attempt to refer a new county tuberculosis plan to the full board acting in its capacity as the hospital's Board of Trustees for evaluation and action. (See story page 2.) Had the procedural maneuver succeeded, abortion opponents could have argued in court that the abortion order was subject to the same scrutiny.

"It was an obvious sub-

(Continued on page 22)



Richard J. Phelan



## ISMS to co-sponsor health care forum

[ WASHINGTON, D.C. ] The Illinois State Medical Society, in conjunction with the Kane County Medical Society, is one of several sponsors of the 1992 Illinois Conference on Health Care chaired by U.S. Rep. J. Dennis Hastert (R-Illinois). Hastert represents the 14th Congressional District, which encompasses Kane County.

Set for Aug. 7 at the Pheasant Run Convention Center and Resort in St. Charles, the day-long forum will offer attendees a look at the various national health care reform proposals circulating in Washington. These include the single-payer, government-run system; the "play or pay" approach; and market-based reform alternatives.

Panel discussions are planned to focus on Illinois health care needs and responses to reform plans and health care for senior citizens. Gail Wilensky, Ph.D., White House deputy assistant to the president for policy development, will deliver the keynote address.

"Because rising health care costs and inadequate access to quality care concern providers and consumers alike, the conference will bring together experts from government, the health care industry, private business and academia to discuss providing such services at reasonable costs," Hastert said.

All physicians are welcome to attend; cost is \$18 for lunch. For more information about registering for the conference, contact Rep. Hastert's office at (708) 406-1114 or the ISMS Division of Governmental Affairs at (312) 782-1654 or (800) 782-ISMS. ■

## New Cook County TB plan revealed

[ CHICAGO ] Cook County Hospital officials have prepared a new plan for attacking the resurgence of tuberculosis in the state's most populous county.

The plan is the result of a task force convened by Cook County Bureau of Health Services Chief Ruth Rothstein in March 1992. Rothstein convened the task force in response to an increase in the incidence of TB after a 35-year decline and the emergence of drug-resistant strains of the TB mycobacterium.

The plan calls for improved diagnostic procedures at all county health facilities, including routine TB screening of patients entering the system; increased use of respiratory isolation rooms in county facilities, including construction of new isolation rooms at the yet-to-be opened Provident Hospital and at Cermak Health Services to accommodate inmates of Cook County Jail; monitoring county health care employees' health; increased coordination with Chicago and suburban public health departments; and appointing of a physician as an interim tuberculosis control director.

The report states that the populations most likely to be hit by the disease have shifted from the elderly in the 1950s to the homeless, immigrants, young adults from racial and ethnic minorities, and people infected with HIV during the 1980s and 1990s.

The plan came to light July 7 when

county commissioners opposed to reinstating abortions at Cook County Hospital used it in a procedural maneuver to thwart Cook County Board President Richard J. Phelan's executive order that permits abortions at the hospital beginning July 30. (See story page 1.) Parts of the TB plan have already been implemented, but the county board's Health and Hospitals Committee will evaluate the plan. ■

## CDC, AMA embark on joint HIV study on M.D. attitudes

[ CHICAGO ] The American Medical Association and the U.S. Centers for Disease Control are conducting the nation's most extensive study about how physicians treat HIV and prevent accidental exposures in their offices. The survey will be mailed next week to 12,000 primary care physicians nationwide, and the results will be used to create HIV and AIDS education programs for doctors and other health care workers, according to the AMA.

"Physicians learn as much about HIV management on the job as they do from any other source," said James S. Todd, M.D., AMA executive vice president. "This survey will ensure that subsequent AIDS education programs are based on the real experiences and knowledge of primary care physicians who deal with the epidemic every day."

The confidential survey will assess different practice patterns of physicians treating HIV-positive patients, Dr. Todd said. Specifically, the questionnaire will ask physicians about their practice types, information they provide their patients about HIV, their knowledge about local and national resources for people with

HIV and AIDS, their attitudes about HIV-infected patients, and the possibility of HIV transmission in their offices.

The survey results, targeted for release in spring 1993, will enable AMA and CDC to "understand the attitudes and approaches of the nation's primary care physicians when treating HIV-infected patients," Dr. Todd noted. "Education is the best way to combat AIDS, and physicians are the first line of defense. Given the strong need to develop quality HIV education programs for the nation's physicians, we urge all those [physicians] who receive the survey to complete and return it as quickly as possible."

Although the original survey draft was written by the CDC, the final survey

reflects input from the AMA, the National Medical Association, the American Academy of Family Physicians, the American Society of Internal Medicine, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the Society for Adolescent Medicine. The AMA is distributing the questionnaires, and the responses will be analyzed by an independent social science research firm. ■

## Cook County included in federal health study

[ WASHINGTON, D.C. ] Cook County has been selected to participate in a National Center for Health Statistics study of people over the age of 2 months. The survey of 399 area residents will take place from July 6 to Sept. 1 in the suburban cities of Westchester and Hines. In all, about 40,000 people will be surveyed.

Conducted in mobile health units, the survey includes demographic, socioeconomic, and diet- and health-related questions. Participants will receive medical and dental examinations, have their physiological measurements taken and undergo several laboratory tests. Health care professionals, including physicians, will perform the evaluations.

Survey results will be used to predict disease prevalence, nutritional disorders and potential risk factors. The survey will address heart disease, diabetes, emphysema, kidney disease and other urologic disorders, osteoporosis, arthritis, infectious diseases, dental caries and periodontal disease, allergies, depression,

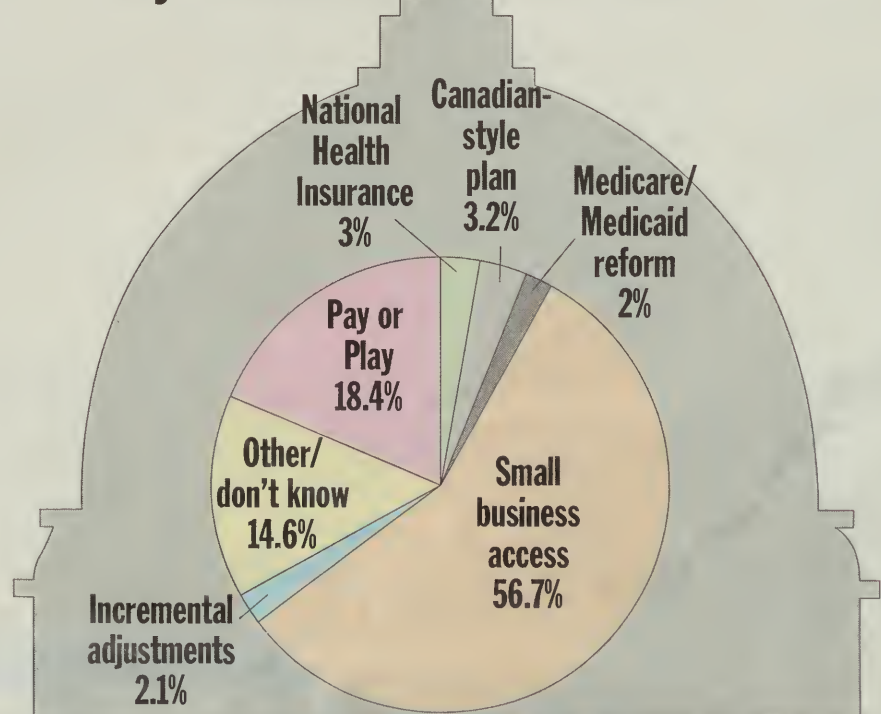


**ERIC MUNKVOLD (CENTER) OF LOMBARD** prepares to shoot as Greg Zajac (left) of Mt. Prospect and Larry Peterson Jr. (right) of Des Plaines look on during a basketball clinic for children with disabilities. The June 20 clinic, sponsored by the Chicago Wheelchair Bulls, The Michael Jordan Foundation and Marianjoy Rehabilitation Hospital, drew 38 participants from Chicago and the suburbs.

## PHYSICIAN FACTS

Congressional senior staff surveyed:

**What type of health care reform, if any, is likely to be enacted in 1992?\***



\* Percent of 311 respondents during January-February 1992 survey. Source: Employers Council on Flexible Compensation, March 1992

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hearing and vision loss, iron deficiency anemia and obesity.

This study marks the third National Health and Nutrition Examination Survey undertaken by the U.S. Public Health Service as a continuing examination of the health of the American public. The Public Health Service has been conducting such investigations for 28 years, collecting health-related information through patient interviews and examinations. ■

## Chicago measles outbreak reported

[ CHICAGO ] Physicians are being asked to monitor children's measles immunization in light of an outbreak this summer. Three cases were reported to the Chicago Department of Health during the first week in July, the department announced July 7.

The reported cases include an 8-month-old girl and her 2-year-old brother from the Logan Square community on the city's near northwest side. Also reported was a case of a 9-month-old boy from Albany Park in the north central part of the city. All three were expected to recover, but the Albany Park youth required hospitalization.

### Confirmed measles cases in Chicago 1988-1992

1988	6
1989	2,232
1990	625
1991	3
1992 (as of July 7)	3

Source: Chicago Department of Health

Public health officials are sounding the alarm because measles epidemics tend to run in three-year cycles, said CDOH officials. The city's last outbreak started and peaked in 1989, finally ending in September 1990. Thus, if epidemiological patterns are accurate, 1992 could see another major outbreak.

Almost 3,000 cases were confirmed during the 1989-90 epidemic, the department said. Of these, there were hundreds of hospitalizations and 11 deaths. Three out of four cases occurred among children under 5, most of whom had not been immunized. Consequently, officials ask that health care providers make a special effort to ensure that patients who require immunizations may receive them.

"We all tend to pay a lot of attention to immunization when there's an outbreak of disease, but vigilance is every bit as important in the quiet months when we don't see measles cases," said Whitney W. Addington, M.D., president of the Chicago Board of Health. "We hope to see more doctors routinely check the immunization status of children."

Department officials said that a recent U.S. Centers for Disease Control look-back study found that in 1988, only 47 percent of Chicago 2-year-olds had received measles vaccinations. A level of at least 70-percent on-time immuniza-

tion is needed to prevent large-scale outbreaks, officials said. During 1991, the health department administered 80 percent more vaccines (220,000 doses) than in 1990 (119,000 doses).

Illinois Department of Public Health spokesman Thomas Schafer said that as of July 13, only five measles cases, excluding the three Chicago cases, have been reported in Illinois. He too emphasized the importance of continually monitoring children's immunizations.

"From our standpoint, it is always appropriate to make sure children are receiving the requisite immunization regimen," said Schafer. ■

## ISMS co-sponsors Home Care Workshop

[ CHICAGO ] The Illinois State Medical Society and the American Medical Association are co-sponsoring Elder Home Care workshops in Illinois. These will teach physicians to identify resources for helping older patients at home and to reinforce the physician's role in home care.

The Illinois chapters of the American College of Physicians and the American Society of Internal Medicine will host the first workshop on Oct. 30-31 at the Packard Building in Peoria. ISMS Secretary-Treasurer David B. Littman, M.D., of Highland Park, is a faculty member, as is Gary McCray, M.D., of Hines VA Hospital. Registration for the entire meeting is \$90 for ACP and ASIM fellows and members. Physicians of all specialties are welcome and are encouraged to contact Joseph S. Solovy, M.D., at (309) 672-5548. ■

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## REPORT FOR *Illinois Physicians*

### A Word from your Medicare B Carrier. . .

The environment for EMC growth has changed radically in the past year. Once an attractive option, EMC has become a practical mandate today. The escalation of health care costs, combined with growing concern over the increased number of uninsured citizens, has focused unprecedented attention on methods for controlling public and private administrative expense.

Blue Cross Blue Shield of Illinois - Medicare Part B believes it is important to recognize that automation will play an increased role in health care in the future. We believe that providers who submit paper claims are at a disadvantage. There will be further incentives for providers to submit electronic claims, and disincentives for paper submitters. For example, providers who are currently modifying their systems to submit the new HCFA-1500 will find it more difficult to contend with future changes than electronic submitters. **There are other developments which demonstrate the short-term inevitability of EMC:**

- The Health Care Financing Administration (HCFA) announced a national goal of 75% EMC from Medicare providers by the end of 1995.
- The President's Plan for Comprehensive Health Care Reform, announced February 6, 1992, relies on EMC as one of five reforms that will reduce public and private administrative expense for health care by 25%.
- The Health Administrative Simplification Act of 1992, introduced by Congressman Fortney Stark (D-CA) on April 9, 1992, would require providers to submit claims using a uniform electronic format to be developed by the Secretary of Health and Human Services.
- In November, 1991, Health and Human Services Secretary Louis Sullivan convened the Forum on Health Care. The Secretary charged this group, representing provider and payor organizations, including the Blue Cross and Blue Shield Association, with reducing administrative cost by developing standards that would facilitate increased Electronic Data Interchange (EDI). The chairman of the forums Workgroup on EDI said recently that the workgroup believes that by 1994 an electronic claims payment system will be fully implemented by the insurance industry. (Bureau of National Affairs Medicare Report, May 8, 1992).

The American Medical Association (AMA) reported that nearly half of all physicians had EMC capability in 1991 (American Medical News, May 18, 1992). Moreover, the AMA report speculated that "it may not be long before the other half of physicians forgo the mail service as a means of sending claims to insurers." Specifically, the AMA Center for Health Policy Research reported that, among the 89% of physicians who billed directly to third-party payors in 1991, 48.3% had EMC capability. Furthermore, 75.3% of the physicians with EMC capability were submitting electronic Medicare claims in 1991, the center said.

Blue Cross Blue Shield of Illinois is committed to working with you to bring the benefits of automation to your practice. Our "Medalist" program, explained in our June Bulletin, will allow providers to identify vendors that are most effective in helping them reduce their work expense through electronic claim submission and electronic information exchange.

We are devoted to sharing with you important information about electronic submission and explaining both current and future advantages to electronic claim submission. If you think faster payment is the only advantage to EMC, you haven't looked at EMC lately!

**Herman J. Strahan, Manager  
Medicare B Provider Education  
& Automation**



# Employee plan, public health programs cut in budget

**BUDGET:** Public health programs and the state employees' health plan were cut under the General Assembly's budget compromise, but Gov. Jim Edgar vetoed \$30 million in appropriations in hopes of covering the workers' plan shortfall. By Tamara Strom

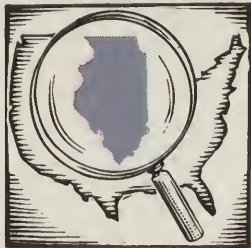
[ SPRINGFIELD ] Paying the health care bills for state workers took center stage as Gov. Jim Edgar signed a compromise budget July 9. Edgar vetoed \$30 million appropriated for various state programs, saying legislators used "smoke and mirrors" to create a "balanced"

budget that left the state employees' health plan severely underfunded.

The General Assembly's budget compromise lowered Edgar's recommended appropriation for the employees' health plan by \$25 million. "That is not a real cut, and all of us know it," the governor said. "It further defers payment of bills to health care providers, and we need to end that practice — not enlarge it."

The state is responsible for paying the health care costs of its employees, regardless of how much money the legislature appropriates. "We're self-insured, so we're going to have to pay for this care," said Helen Adorjan, spokeswoman for the state Department of Central Management Services, which administers the health plan. "[The cuts are] not a savings; it's just a deferral."

Even though Edgar slashed \$30 million from other areas to cover the



employee plan shortfall, the necessary funds cannot automatically be transferred to the health plan, Adorjan said. "[The governor] can't transfer money between lines. It will have to come to us as a supplemental appropriation from the General Assembly."

That news does not bode well for physicians who treat state workers. Currently, physicians are waiting more than 100 days to be reimbursed for care given to state employees, Adorjan said.

As of July 10, the state had completed paying doctors' claims received March 27, Adorjan said. "Now we're even about two weeks behind our 'slowdown schedule' because of the end of the fiscal year. But we hope to catch up these two weeks very soon."

"If the total appropriation isn't enough to cover this year's anticipated costs, the payment cycle will not speed up," Adorjan said. No "big chunk" of funding from fiscal 1993 will be used to catch up on last year's bills, she explained. Although the governor infused \$100 million into the health plan to pay provider bills this spring, it was not sufficient to cover all bills submitted

in fiscal 1992, which ended June 30. The state is carrying over more bills into this year, Adorjan said, adding that these claims cannot be paid until there is enough money in the state treasury.

**THE GOVERNOR'S VETO PEN** also struck programs administered by the Illinois Department of Public Health. Edgar cut \$1 million in grants to local health departments, \$1.2 million for the Illinois Cancer Center and more than \$73,000 for IDPH's fluoride monitoring program. These cuts, coupled with reductions made during the budget process, will force IDPH to eliminate some public health programs, said department spokesman Tom Schafer.

"The fat is gone; these cuts mean there will be programs eliminated," Schafer said of the \$6 million IDPH lost in budget negotiations. "We were cut 11 percent [for fiscal 1993] on top of the 20 percent we've already lost since the governor made cuts in January and again in April."

Public health did manage to retain near-current funding levels for its core prevention programs such as AIDS services and education efforts, and infant mortality programs. The General Assembly, however, erased the \$300,000 Edgar had slated to implement S.B. 999, the compromise HIV notification law passed last year. Instead, lawmakers appropriated \$1 to fund the notification program.

"We can't do anything except spend that \$1," Schafer said. "We can't take additional funds from other areas because they listed it as a separate line item."

**INFANT MORTALITY FUNDING** was held "sacred" by both the governor and the General Assembly, Schafer said. The department protected \$16 million in funding for its programs and received an additional \$4.5 million in federal monies for the Healthy Start program, he said. Although the state cut by 6 percent the General Revenue funds used for the Women, Infants and Children program, this year Illinois will receive "huge increases in federal funds that allow for significant growth in the WIC program," Schafer added.

When signing the fiscal 1993 budget, the governor also cut \$1.3 million from the treatment programs monitored by the Department of Alcoholism and Substance Abuse.

Not all news from the budget compromise was bad for health care programs. Edgar did approve an 8.5 percent hike in the Medicaid physician line. Illinois physicians will receive higher reimbursement from public aid's new Healthy Moms, Healthy Kids program. The \$19 million managed care program, set for implementation Jan. 1, 1993, will focus on delivering primary and prenatal care to expectant women, new mothers and their children.

"If we had the money, I would not have vetoed many of these appropriations," Edgar said. "But we simply cannot afford them this year." ■

## Office poster features ISMS principles of health care reform

This issue of *Illinois Medicine* includes a poster featuring the Society's policy on health care reform. Adopted by the ISMS House of Delegates in April, these principles can shape the debate on reform in Illinois and nationally. The poster is suitable for display in your office, your lab or your reception area; copies have been sent to the Hospital Medical Staff Section for posting in staff lounges in hospitals.

A handout included in the last issue of *Illinois Medicine* contains a detailed explanation of the Society's guidelines for health care reform, a topic that will highlight this year's elections. These are appropriate for sharing with your staff, your patients, your family and your colleagues.

Additional copies of both items are available from ISMS. Call (312) 782-1654 or (800) 782-ISMS. ■

## Judges sue the state over increased costs in employees' health plan

**JUDGES:** The Illinois Judges Association is suing the state, claiming benefit reductions. By Tamara Strom

[ SPRINGFIELD ] While the state's employee health insurance plan struggles to pay health care providers, the Illinois Judges Association has filed suit against the state, claiming an unfair loss of benefits. Since Jan. 1, 1992, all state workers, including judges, have contributed premium payments to the employees' health plan and have paid higher deductibles. These increases were implemented on a sliding scale, depending on employee earnings, according to the plan's administrators, the Department of Central Management Services.

Since the starting salary for Illinois judges is just over \$80,000, they must pay the premium and deductible levels in the state's highest income category — over \$50,000. This translates into a \$12.50 monthly premium and a \$300 yearly deductible. Deductibles for dependents remain at \$100 a year.

The attorney for the 800-plus member judges' association said premiums and deductibles were not the only cause of the suit. "The bigger complaint is that the increase in the [copayment] contribution from 20 percent to 40 percent impacts very heavily for judges out of the Chicago area, where PPOs are not as numer-

ous," said Leonard M. Ring, counsel for the Illinois Judges Association and a prominent Chicago-area plaintiff's attorney. Ring noted that with the increased copays, judges face higher health care costs. Some may wish to choose PPO hospitals or physicians that typically have lower fees, he said. But outside of large metropolitan areas like Chicago, "where there is a shortage of PPO physicians and facilities, judges and their families are paying a lot more to see [non-PPO] physicians. This is something the government did not take into account when making these changes."

Ring said non-PPO physicians are being discriminated against, since judges may decide not to choose them as their doctors because their fees may be higher than PPO prices.

The difference between a 20-percent copay and a 40-percent copay can be significant, Ring said, citing a person who undergoes a minor procedure at a hospital and receives a bill for \$12,000. "[The judge's share] would be \$2,400 with a 20-percent contribution and \$4,800 with a 40-percent contribution," he said. "Then you have to add on the physician's services. So you can see that difference makes a big, big difference." ■

## General Assembly calls for health care task force

[ SPRINGFIELD ] Citing the need to revamp aspects of Illinois' health care system, the General Assembly this month called for the creation of the Illinois Health Care Reform Task Force. The task force — established through a provision in the state's Medicaid Revenue Act, which reconfigured the state's health facilities assessment program — will be charged with studying long-term strategies for containing health costs in Illinois.

To be convened by Gov. Jim Edgar within 90 days of the Act's July 1 effective date, the task force will examine ways to alter the state's current health delivery systems and will recommend treatments for the ills of the Illinois Medicaid system.

Appointed by Edgar, task force members will include representatives from the medical, academic and business communities; the hospital and long-term care industries; the general public; and government officials, including lawmakers.

Because health care is expected to remain high on legislators' agendas, the task force may serve as a public forum to address health care reform proposals such as a state-run, single-payer system, observers note. Medicaid reform, however, is expected to be the focus of the group's efforts. Previous health care summits held in Illinois produced detailed plans to correct deficiencies in the health delivery system, but these plans fell victim to a lack of funding to implement them. Without an infusion of funds into the state's Medicaid program, the upcoming summit could face a similar fate. ■



# "Operation Precious Cargo" helps protect young lives

**CHILD SAFETY:** A new program of the Illinois Office of the Secretary of State provides infant safety seats to families that need them. By Anna Brown

[ SPRINGFIELD ] About 1,000 Illinois children now will be a lot safer when riding in the family car. Since February, the Illinois Office of the Secretary of State has been loaning infant safety seats to families who need them through its "Operation Precious Cargo" program.

Secretary of State George H. Ryan purchased 1,000 car seats for the 111 driver's license examining stations in Illinois with funding from the Northbrook-based Allstate Foundation. Since 1983, Illinois law has required that children up to age 4 be restrained by a safety seat while traveling in a private car.

"These seats give our most vulnerable child passengers a fighting chance in a collision," Ryan said announcing the program. "Nearly 1,300 children under age 12 died in 1990 while riding in a car, and the highest death rate was among those who hadn't yet celebrated their first birthday."

The seats may be obtained on a first-come-first-served basis, said Ryan's spokesman John Torre. The seats are being loaned at no charge to anyone who can't afford one, hasn't bought one yet or needs one for only a short time.

The restraint seats offered by the state are for infants up to 9 months of age, Torre said.

The loaner program is the second phase of the "Operation Precious Cargo" initiative, which encourages Illinois motorists to secure child passengers in car seats or seat belts. The first part of the program used a federal grant to equip all Secretary of State police cars with car seats. Police who stop drivers for traffic violations and find an unrestrained child in the vehicle will loan drivers a car seat and teach them how to use it.

Ryan also mailed "Operation Precious Cargo" posters to Illinois pediatricians with a letter asking them to "use your position to teach citizens of Illinois about safety."

Andrew M. Basile, D.O., an emergency physician and member of the Secretary of State's Traffic Safety Advisory Committee, said physicians should "definitely question their patients on whether they are using car seats, and advise them about the Secretary of State's program."

"As I travel through the city, I can't help but notice kids crawling around in the back windows of cars," he said. "It's very prevalent."

Dr. Basile said Illinois ambulances carry infant restraint seats, which are good immobilization devices. "EMTs can remove kids in the car seat after an accident," he said, noting the device stabilizes the back without the need for a backboard.

"It's also important that children don't use the same car seat as they grow," he stressed. "Younger children need rear-facing seats, while older children need bigger, front-facing seats." All car seats are secured by seat belts, he explained.

In his practice, Dr. Basile has seen the benefits of infant safety seats. He described an incident where a baby was

secured in a rear-facing car seat in a Mazda Miata convertible. The mother, who was driving without wearing a seat belt, lost control of the vehicle and, as it flipped over, was thrown out of the car and killed. The child was suspended upside down in the seat, unhurt.

"That's an amazing testament to the car seat," Dr. Basile said.

**THE YELLOW CAB CO./Checker Taxi Co.** of Chicago in May took steps toward child safety in the spirit of "Operation Precious Cargo" by providing infant safety seats in 200 of 700 radio-dispatched cabs, said spokesman Jan Johns. Cabs will store the seats in their trunks, and

callers can request a vehicle with a safety seat.

"We take safety and service seriously at every level," said Yellow/Checker President Jeffrey M. Feldman. "We are proud to pioneer this program to enhance the security of our smallest passengers."

Johns said that while commercial vehicles are not required to comply with the child restraint law, Feldman wanted to take added safety precautions in the cabs the company owns. The program, "Yellow Cab Cares," is receiving full support from "Operation Precious Cargo," Johns said, and may expand to equip more vehicles if successful. ■



## MEMBERS IN THE NEWS

Alan M. Roman, M.D., of Flossmoor,

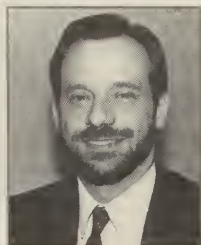


was installed as president of the Chicago Medical Society at its annual meeting on June 13. Dr. Roman, a general surgeon, is a past chairman of the Chicago Medical Society Board of Trustees and first vice president of the Illinois State Medical Society. He also serves on the Board of Governors of the Illinois State Medical Inter-Insurance Exchange.

A graduate of the Chicago Medical School, Dr. Roman is associated with Pronger Smith Medical Associates and is chairman of the department of surgery, director of the surgical intensive care unit and a member of the Executive Committee at St. Francis Hospital in Blue Island.

Other elected CMS officials include Sandra F. Olson, M.D., president-elect; Biswamay Ray, M.D., secretary; John F. Schneider, M.D., council chairman; and Dennis M. Brown, M.D., council vice chairman.

Mark R. Ottolin, M.D., of Wheaton,



was named medical director of the heart center at Copley Memorial Hospital in Aurora. He is currently medical liaison to the Copley medical staff, and chairman of the hospital's Cardiac Catheterization Committee. Dr. Ottolin is a fellow of the American College of Cardiology, and is on the faculty at Grant Hospital and St. Joseph Hospital in Chicago.

J. Martin Stoker, M.D., of Oak Brook, received Elmhurst Memorial Hospital's Distinguished Service Award from the hospital's medical staff for his leadership and dedication to the medical profession. A 37-year medical staff member, Dr. Stoker

founded the hospital's nuclear medicine department in 1958 and served as its medical director until 1966. He has been chairman of the department of medicine, medical staff president and a member of the hospital's Board of Governors. Currently, Dr. Stoker serves on the Board of Directors and Executive Committee of Crescent Counties Foundation for Medical Care.

George T. Mitchell, M.D., of Marshall,



received the 1992 Lake Land College Distinguished Service Award at the college's 25th annual commencement ceremonies May 15. A committee of college employees and Board of Trustees members selected him, citing his support and contributions to the college. Dr. Mitchell, a family physician, served on the Lake Land board for 14 years, including terms as chairman, vice chairman, secretary and board representative for the Lake Land College Foundation. He has practiced medicine in Marshall for 46 years and is a staff member of Union and Regional hospitals in Terre Haute, Ind.

The Women's Encouragement Board recently presented Paula Youngberg Arnell, M.D., of Moline, with the Marguerite Brooks Award for Health at its seventh annual luncheon. WEB is a network of women's organizations dedicated to educating women leaders, encouraging career planning and providing guidance for young women.

Dr. Arnell has long been interested in women's health issues and played a lead role in establishing the Quad Cities' first regional screening and diagnostic breast cancer center. A Quad Cities native, Dr. Arnell is a graduate of the University of Iowa Medical School. She is medical director of the Metropolitan Medical Laboratory and a founding member of the Mississippi Valley Blood Bank.

Five members were elected medical staff officers at Saint Mary of Nazareth Hospital Center in Chicago. John P. Monteverde, M.D., of Oak Brook, who was elected president, is a cardiologist who joined the medical staff in 1979. Nam S. Huh, M.D., a surgeon from Barrington Hills who joined Saint Mary's in 1974, is president-elect. Internist Mila Bacalla, M.D., of Lincolnwood, was elected secretary; Mouhammad F. Tarsha, M.D., an anesthesiologist from Oak Brook, was elected treasurer; and urologist Thomas C. Malvar, M.D., of Glenview, was elected staff representative to the American Medical Association.

Suresh P. Agarwal, M.D., of Hinsdale,



was elected president of the medical staff at Ingalls Memorial Hospital in Harvey, succeeding cardiologist Imtiaz S. Hamid, M.D., of Flossmoor. Dr. Agarwal has chaired the hospital's department of anesthesiology, Quality Assurance Committee, Accreditation/Medical Records Committee and Respiratory Care Committee. He is joined by Vice President Mark I. Kozloff, M.D., of Flossmoor; and Secretary/Treasurer Jayant Malhotra, M.D., of Homewood. Both are internists who joined the medical staff in 1977. Other members elected to serve as clinical department chairmen at Ingalls were Bruce Parisi, M.D., of Chicago, family practice; Ruben Chuquimia, M.D., of Flossmoor, internal medicine; Doris E. Wickman, M.D., of Homewood, obstetrics and gynecology; Baroukh Radfar, M.D., of South Holland, pediatrics; and Bohdan A. Iwanetz, M.D., of Lansing, surgery.



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## EDITORIAL

# The dance of legislation

**M**aking laws in a democracy is a process, with rules and procedures to be followed, much like steps in an intricate, disciplined dance. New dancers entering the legislative arena who don't learn the steps, who go their own way on the dance floor, slow and disrupt the process and lower the quality of the dance.

ISMS, representing 18,000 Illinois physicians and medical students, is a "regular" on the dance floor, experienced and respected in the legislative process. Our seasoned physician leadership and staff have taken the time to learn the process, develop credibility for physicians, and build relationships with elected and government officials, in order to advance the cause of patients and physicians. Each session, ISMS reviews, monitors and educates legislators about how hundreds of proposed laws will affect patients and physicians. ISMS has earned a reputation of being an honest, tough advocate.

Often our stances are difficult and complex. Sometimes a legislator introduces a bill that, with work, can be improved. Sometimes, no amount of work can improve the bill. But ISMS knows the process and the players. We work toward the best available outcome within the overall legislative framework.

For years ISMS has encouraged your involvement in the legislative process. We know the best combination for legislative success is positive election outcomes, professional, experienced and

respected staff, plus member commitment and contact.

However, the surest way to reduce our effectiveness is member involvement that is self-serving, clumsy and oblivious to the overall consequences for our profession and patients. Unity in the profession has never been more important. Nationally, the example that comes to mind is RBRVS. In spite of warnings to the contrary, the RBRVS proposal pitted specialty against specialty. Now nobody's happy with the outcome. At the state level, self-referral and lethal injection were topics that divided the profession. The concrete advantages to unity outweigh the disadvantages. The issues may change, but medicine's need to maintain a unified voice remains. If you have a cause that deals with health care, work through our internal ISMS democratic process, the House of Delegates. Let's all work together.

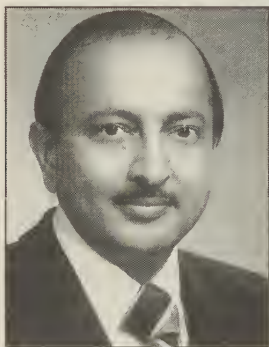
ISMS carefully choreographs legislative strategy and gets the job done. Sometimes, we have to wait several sessions before the timing is right and the proposal is acceptable to legislators. Sometimes, we have to accept an imperfect proposal, knowing that in a future session we can try to perfect it.

With the session adjourned, ISMS renews its activities to elect candidates in November who will listen to medicine's views. Next January, the legislature convenes again in Springfield. It's all part of the continuous dance called the democratic, legislative process. ■

## PRESIDENT'S LETTER

# Destiny can be a matter of choice

By Arvind K. Goyal, M.D.



*"Unlike most patients with advanced emphysema, there was no 'no code blue' or DNR order on his chart."*

**A** young preacher came to a distant settlement to reform the natives. He stopped at old Nancy's cabin and found her smoking. "Aunt Nancy, when your time comes, do you expect St. Peter to let you into heaven with tobacco on your breath?" he asked. Taking her pipe out of her mouth, she responded, "Young man, when I go to heaven, I expect to leave my breath behind."

John told me this story on his first visit to my office about six years ago. And then he pleaded, "So I'm here, Doc, and I want you to clean whatever breath I have left." He was 67 then and admitted he had smoked "longer than I can remember." A severe choking spell after mowing his lawn led him, via an emergency room and a pulmonologist, to a rehab hospital in Chicago, where he was told, "You could blow up the oxygen tank if you ever light up again," a warning his wife didn't take lightly. In John's words, "That ended my smoking career."

His coughing spells came more often. He now "smoked" oxygen and inhalers p.r.n. and he "popped" several pills every day. He ate, talked and walked slowly, requiring deep breaths in between. He slept on two pillows, then three and finally a recliner chair seemed to provide the best respite!

John worried about his worried wife. He said he would do anything for her, "I want to be with her as long as I can, so she won't need another chauffeur." He decided to see me, since I had been his wife's doctor for years. That may make her happy, he thought, it's the "ultimate flattery."

On his second visit, he told me he had seen his mother-in-law die of a stroke at age 92 while under my care several years ago and had appreciated the fact that she was comfortable all the way to the end, that I hadn't hooked her up to some machine, and that she had talked with him a few hours before it all ended.

John later confided the real reasons he came to see me. He knew he had a terminal disease and he was afraid of dying, even more afraid of pain. He wanted to go peacefully when his time came. He did not want to live in a nursing home or away from his wife. He told me about his fear of hospitals: "Those damn intense care units with everybody on some kind of a machine scare me." And he finally dictated: "Don't make me see any more doctors. I've already gotten second opinions from most everybody in the phone book."

John had indeed verbalized an advance directive: no machine care. No artificial prolongation of life. No consultations or sophisticated diagnostic tests. Just peace and comfort, no pain. And in so many words, a health care power of attorney: "You listen to my wife, if I can't talk." He emphasized, "Even I listen

to her." That directive was formalized a few years later when he handed over two sheets of legal-sized paper to me, saying, "Here is your copy of our contract."

John had some ups and downs along the way. A few episodes of pneumonia required hospitalization. When cataracts developed on maintenance cortisone, surgery brought some of his vision back. A ruptured biceps seemed to rupture his spirit temporarily, and a fall broke a few ribs. In between times he would feel better, and talk about lung transplants! But overall he made out, from one vacation to the next. Only occasionally did he get in trouble when out of town. I remember him complaining about his visit to an emergency room in Las Vegas "I wasted half a day of my vacation there; they didn't even have a slot machine." And more recently he cut short his Texas vacation and had his wife drive him back to see me because "I didn't want to die in Texas."

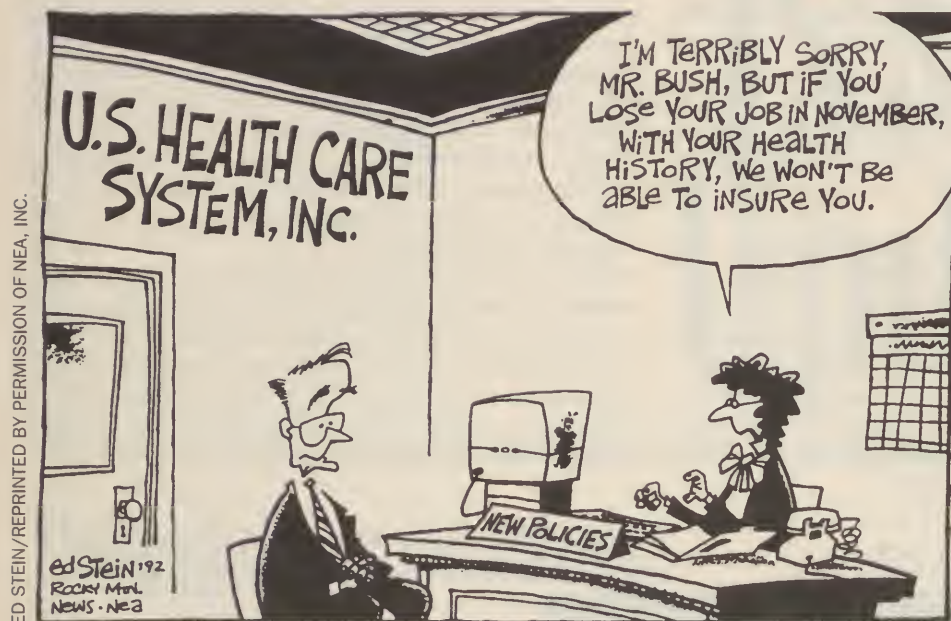
A few months ago, John required what would be his final hospital stay. He couldn't breathe in spite of oxygen and a maximal dosage of oral cortisone and other medications. We decided to try IV medications and respiratory therapy around the clock. He wasn't comfortable talking, but managed to tell me, "I am already out of warranty; see what you can do." I left orders on the chart verifying the existence of advance directives and "no machine care." Unlike most patients with advanced emphysema, there was no "no code blue" or DNR order on his chart! That worried the nurses and the hospital administrators. They weren't used to anything that wasn't here or there. They couldn't understand my firmness, my desire to do just what the patient may have asked! I wouldn't transfer him to the ICU, yet I wanted him resuscitated, up to a certain point! I logged 22 calls over one 24-hour period, and at least half of those were nothing but expressions of anxiety on the part of concerned hospital personnel.

His wife got a little nervous when she started to get questions she couldn't answer. Her favorite line, "Ask our doctor if you are not sure," served all of us well.

I had my final conversation with John and his wife on day five of his hospitalization. John seemed content and ready to go. He did indeed die later that night, when he was pronounced dead after a short resuscitative attempt - no machines and nothing he didn't want!

His wife had the last word. She called me later that night to tell me, "You needn't feel bad; you did your best." And the following week, she stopped by my office to drop off her own living will.





## GUEST EDITORIAL

## A bad prescription for health care crisis

There are literally dozens of "solutions" to the health care crisis floating around the country. Some offer good ideas. But some, like the universal health care bill in Illinois, are nearly all bad.

The Illinois [State] Medical Society and other opponents of the universal health care plan pending before the Illinois General Assembly are calling it a "prescription for disaster." The description is apt.

In their zeal to do something about the growing problem of inadequate, overpriced health care, lawmakers are in danger of killing the patient through overmedication.

Illinois taxpayers would do well to remember the warning: If it sounds too good to be true it probably is.

The idea of equal, high-quality health care for all Illinois citizens, regardless of their socio-economic background, is more than a little appealing. It's even more attractive when it's sold as low-cost. And various proponents have claimed that universal health care will cost Illinoisans nothing, very little, or the most ridiculous claim, that it will save money. Hogwash.

Even if the Illinois [State] Medical Society's figure of \$54 billion in annual costs is inflated, it's not inflated by much. And it's telling that the bill that creates universal health care offers no funding mechanism to pay for it. Some lawmakers are saying, "Don't worry about that now. It's more important to get the bill passed, and we'll worry about paying for it later."

That's the kind of thinking that has landed the federal government – and now many of the states – in the never-ending pit of debt that's threatening to drag us all down.

That's just one of the reasons that the idea of state government, or any government, running such a comprehensive program should strike fear into the

hearts of all taxpayers. Illinois can't even pay what it owes to hospitals, pharmacists, nursing homes and doctors for treating Medicaid patients. Neither can it provide for the health care insurance of its own employees. How can we expect it to do so for all the rest of us?

And those are just some of the financial problems. Consider the impact the proposal will have on the quality of health care in Illinois. Though proponents argue that a statewide insure-everybody system will not lead to health care rationing, it's almost impossible to avoid it. If the state has, say \$60 billion budgeted for health care this year and by November the fund runs dry, what is government likely to do? Increase taxes, borrow money or, more likely, begin restricting the procedures state health insurance will pay for.

Lawmakers should continue to work toward resolving the health care problem. One good place to start is a bill pending before Congress that was authored by U.S. Rep. Dan Rostenkowski, (D-Illinois). That bill offers a host of incremental savings aimed at bringing health care costs down, and helping small businesses to provide coverage for their workers.

Some of President Bush's proposals also are attractive, including malpractice reform. Other ideas should be explored.

We must find answers to the health care crisis. We must find a way to insure the uninsured and boost the coverage of the underinsured. We must bring down, not just stabilize, skyrocketing health-care costs.

But "universal health insurance" is the wrong prescription. Its side effects, not yet effectively measured, could prove fatal to the state's budget and to the quality of health care for the citizens of Illinois.

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## GUEST EDITORIAL

## A radical remedy for the dearth of transplant organs

By Stephen Chapman

Every year, thousands upon thousands of healthy people in this country have the bad luck to end up in accidents (auto wrecks, gunshots, drownings) that leave them completely defunct but their vital organs in perfect condition for transplantation. Yet most of these body parts end up in cemeteries, not in the people who need them. Last week at the University of Pittsburgh, doctors transplanted a baboon liver into a dying man on the faint hope of finding an alternative to scarce human organs.

Medicine has made huge progress in recent years in organ transplants. The success rate ranges from about 70 percent for livers to more than 90 percent for kidneys. But the number of organs available hasn't kept pace with the soaring need. More than 27,000 people are on the national waiting list for transplants, but only about 4,500 people donate organs each year.

Nationally, about 30 percent of the patients who need a new liver die before getting one. There are 120,000 Americans enduring the miserable ordeal of long-term kidney dialysis – most of whom would benefit from kidney transplants and few of whom will ever get them.

Various methods have been tried to close the gap: media campaigns to promote organ donation, putting donor cards on driver's licenses, rules ordering hospitals that get federal funds to make requests of the next of kin of dead patients.

None has worked very well, because doctors don't like to add to the troubles of bereaved families, and bereaved families don't like to tamper with the bodies of their loved ones. Even when the deceased has signed a donor card, hospitals generally decline to harvest his organs without the family's consent, which is not always forthcoming. Some countries have laws allowing hospitals to take organs without asking anyone. In practice, though, most doctors aren't willing to do so.

Communist countries once faced chronic shortages of basic goods for the simple reason that they didn't allow prices to balance supply and demand. The same failure is at work here. Those people with organs to give have no economic incentive to do so, so most of them don't bother.

Lloyd Cohen, a professor at Chicago's IIT-Kent College of Law, has a solution: Let healthy people enter into contracts to sell their organs after death, with the money payable, like life insurance, to designated survivors. At an estimated price of about \$5,000 per usable organ, the beneficiaries could reap \$35,000 or so for a full set of lungs, heart, liver, kidneys and pancreas.

That's enough money to be a potent lure for the complacent to sign up to donate their usable remains – but not enough to price anyone out of a transplant operation, which already can be expected to run into the hundreds of

thousands of dollars.

Cohen envisions a national registry with a toll-free number that would let doctors and hospitals determine immediately if someone has agreed to let his organs be taken, letting them avoid the painful job of approaching sobbing relatives. He also thinks they should be held legally liable for complying with the wishes of the person involved – since any failure will be a great loss to his estate.

The hospital, having responsibility for the body of the deceased, "will be required to take as much care with it as with his wallet and watch," wrote Cohen in an article in the *George Washington University Law Review*. "That is, to preserve it and deliver it to the proper party." One or two negligence awards against hospitals that fail should ensure proper attention.

*"People who carry healthy organs to the grave likewise do themselves no good, while depriving others of the means of life."*

The usual reaction to this proposal is horror at the notion of trafficking in human flesh. But the only flesh that will be bought and sold is that of cheerful volunteers, who will be safely dead before any money changes hands. We aren't horrified when a hearty young man helps pay his college tuition by regular contributions to a sperm bank; why should we care if he wants to make money off his other organs once he no longer needs them? Rest assured that clever lawyers can also devise contracts that prevent murderers or suicides from turning violence into profit.

People repelled by this proposal should turn their eyes to something even less appetizing – the thousands of people who die every year because of the maddening shortage of livers and kidneys. When your life is at stake, it's hard to see the value of the principle being upheld by our current policy.

Shakespeare wrote that "he who filches from me my good name robs me of that which not enriches him, and makes me poor indeed." People who carry healthy organs to the grave likewise do themselves no good, while depriving others of the means of life. Letting the market do its job, on the other hand, would reward the generous and rescue the needy.

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## President Bush pushes caps on Capitol Hill

**TORT REFORM:** President Bush sent his malpractice reform program to Capitol Hill. By Tamara Strom

[ WASHINGTON, D.C. ] President Bush is taking his fight to enact tort reform to Congress, unveiling his medical malpractice reform proposals during a July meeting with Republican congressional leaders. The plan mandates non-binding arbitration for medical malpractice claims filed by patients enrolled in government-funded health plans, such as Medicaid and Medi-

care. Bush's reform plan also calls on states to pass other tort reform measures, namely \$250,000 caps on non-economic damage awards.

"Today, I'm asking all Americans to help me break a logjam holding up reform," Bush said during a July 3 radio address. "Health care in our country is too expensive, too complicated. And too often, the system is downright unfair."

Although medical malpractice reform was listed as a key element of the president's health care reform proposal released in February, the Bush administration had not pursued formal legislative action on its program until recently. With the November election campaign heating up on the domestic front, Bush has seized the opportunity to send four bills to Congress aimed at getting his health care program off the ground, according to the American Medical Association.

The president's malpractice reform initiative – the Health Care Liability Reform and Quality of Care Improvement Act – also encourages states to create pilot projects for prompt payment of actual medical expenses to avoid dragged-out lawsuits that clog an already overburdened court system. But with most health proposals tied up in committee because of election-year politicking, passage of the plan seems unlikely this year, the AMA said.

Medical malpractice-related costs directly impact the country's skyrocketing health care costs, the AMA noted. During the 1980s, malpractice insurance caused the largest jump in annual physician costs, averaging about 21.9 percent a year. Currently, the Bush administration estimates the price of defensive medicine caused by fear of litigation is \$21 billion a year. ■

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# ISMIE Update

Case in Point  
takes a look  
at informed  
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## Policyholder relations: Strengthening service

**SERVICE:** The Exchange policyholder relations department is the physician's first contact for questions or claims reporting. By Anna Brown

[ CHICAGO ] How many times have you called the Illinois State Medical Insurance Exchange in the past year? If you reported a claim, chances are you spoke with a policyholder relations representative who took you through the first steps of preparing for or avoiding a lawsuit. Perhaps you had a question about your policy, or you needed more information about the National Practitioner Data Bank. The policyholder relations department probably saved you the time and inconvenience of being transferred to several different departments.

Fielding an average of 50 to 75 calls a day, the policyholder relations department was creat-

ed for the purpose of better serving physicians. It serves as an entry point for the Exchange Underwriting and Claims divisions; policyholder relations representatives are cross-trained and knowledgeable about both divisions.

"The policyholder relations department has made real advances in service for physicians," said Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors. "Policyholders can easily report incidents and claims and obtain information with little hassle, thanks to knowledgeable representatives and a streamlined computer system. This also

helps underwriters and claims analysts more efficiently serve new customers and physicians defending suits."

**AN IMPORTANT POLICYHOLDER** relations function is collecting information about potential claims. When a policyholder reports an incident that could lead to a claim, the policyholder relations representative creates

a file on the specially designed data base. He or she requests copies of all documents the policyholder receives that pertain to the incident. This file, containing all initial information, is assigned for follow-up to a professional liability analyst in the Claims Division.

The department serves the Underwriting Division by fielding questions regarding bills,

address changes and loss history. Its recent innovations include creating a "service action form" that a representative completes if a policyholder has a specific concern that may need to be addressed by another physician or staff member. The department also helps policyholders settle their accounts and avoid cancellation when the Exchange receives partial payment on premiums.

"For these services, the comprehensive data base is a distinct advantage," Dr. Boren said.

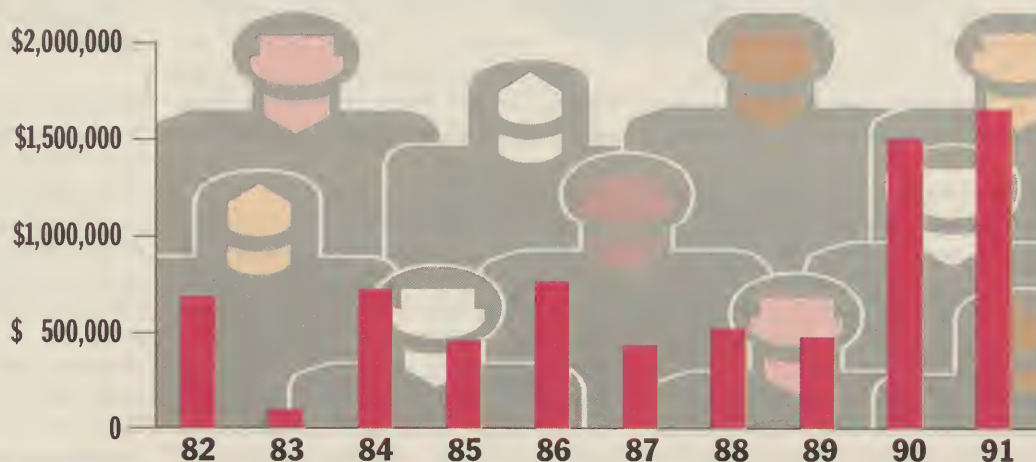
Policyholder relations will often take on overflow from both Claims and Underwriting. For example, the department generates loss history letters to hospitals when physicians join their medical staffs.

**ALL CLAIMS CLOSED** with indemnity are reported to the National Practitioner Data Bank and the Illinois Department of Professional Regulation, as required by state and federal laws.

Data Bank reports include synopses of the claims and parties involved. The policyholder relations department provides policyholders the opportunity to review reports for accuracy before they are filed. However, corrections can be made even after reports are filed.

Policyholders who need to report incidents or who have questions can contact the policyholder relations department by calling the Exchange at (312) 782-1654 or (800) 782-ISMS. ■

### Average jury verdicts in Illinois, 1982-91



Source: Cook County Jury Verdict Reporter; (312) 644-7800.

## MALPRACTICE ROUNDUP

### Defensive medicine rates high

The American Medical Association reports in its *This Week* bulletin that an AMA-sponsored Gallup survey showed that 84 percent of U.S. physicians say because of the threat of malpractice suits, they administer tests that may be unnecessary. Sixty-one percent of these physicians also say that their defensive medicine significantly increases the cost of the care they provide.

Addressing patient compensation, the survey found that about half of the physicians surveyed think injured patients should be compensated through a no-fault system, and 40 percent think patients should be required to prove the provider was at fault. ■

### Neurosurgeon not liable for resident's negligence

A case reported in the May 1992 issue of *The Malpractice Reporter* explored the liability of a Louisiana neurosurgeon for the negligence of a medical resident under his supervision. The neurosurgeon performed a DREZ lesion on a patient who was paralyzed in the right arm and right diaphragm and suffered from phantom pain in the shoulder.

Although the neurosurgeon left the hospital while the resident attended to the patient in the recovery room, he returned immediately after hearing that the patient could not move his extremities and performed a second surgery to remove blood clots compressing the spinal cord. The patient suffered necrosis of the

spinal cord and died of collapsed lungs nine days later.

The neurosurgeon testified that he should have been informed sooner that the patient was unable to move his legs and arms, because the resident knew this for three hours after surgery. The plaintiff alleged that the resident breached the standard of care by failing to act in a timely manner and that the neurosurgeon was liable for that damage as a result of a teacher's responsibility for a student. The neurosurgeon testified that he did not breach the standard of care by leaving a licensed physician in charge of his recovering patient.

The jury rendered a verdict finding the neurosurgeon 40 percent negligent. This judgment was reversed on appeal, attributing 90 percent liability to the resident and 10 percent to the hospital. Louisiana has a law that allows apportioning of responsibility — Illinois does not. ■

### Parents win wrongful birth suit

*The National Law Journal* reported June 1 that a Wilmington, Del., jury awarded parents of a 5-year-old child with Down's Syndrome \$788,000 because a laboratory did not notify them of the condition in time for the mother to abort the fetus. The court allotted the sum for only those costs related to the handicap; a guardian will oversee distribution of the award.

The medical center named in the suit had not decided whether to appeal but issued a statement of sympathy to the parents. ■



# Case in Point

by Carol Brierly Golin

*A regular feature using hypothetical case histories to illustrate loss prevention maxims.*

## Case #1

### Presenting complaint and initial diagnosis

— A 47-year-old man went to a general practitioner, complaining of a lingering respiratory infection. After completing a work-up, the physician found the patient had an elevated white cell count and a lump in the area of the left clavicle. Suspecting lymphoma, the doctor referred the patient to a surgeon.

**The case in brief** — The surgeon recommended a biopsy, and the patient signed a consent form authorizing a biopsy only. The surgeon completed the biopsy and also removed the entire lump, which proved to be a benign schwannoma. During the surgery, a main nerve trunk of the brachial plexus was severed, and the patient lost sensation in his left arm below the elbow. A subsequent nerve graft was unsuccessful.

**The resulting claim** — The patient sued the surgeon for negligence, alleging that he had consented to a biopsy only and would not have suffered permanent nerve damage had the surgeon not attempted to remove the lump.

**The outcome of the claim** — The surgeon argued that the patient would have suffered nerve damage in his arm if the tumor had not been removed promptly and that nerve damage is a risk of surgery. Because the patient consented to

a biopsy only and suffered permanent residual damage as a result of the more extensive surgery, the case was settled for \$750,000.

## Case #2

### Presenting complaint and initial diagnosis

— A 23-year-old woman complained to her gynecologist of excessive facial hair growth and a history of chronic pelvic pain. The gynecologist referred her to a university medical center where she underwent laparoscopic surgery that revealed polycystic ovarian disease. She was prescribed large doses of birth control pills to ease her pain. At age 29 she stopped taking the birth control pills because of side effects. Her pelvic pain returned, and she was referred to an endocrinologist.

**The case in brief** — The endocrinologist referred the patient to a gynecologic surgeon who recommended another exploratory laparotomy. The patient consented to removal of any organ during the procedure if sufficient pathology was found but asked that her ovaries be left in place if normal. During the laparotomy, the surgeon performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy and removed an inflamed appendix. The pathology report indicated the patient's reproductive organs were normal. Over the next two years, the patient's pelvic pain returned, and the hirsutism worsened. She saw another endocrinologist, who administered treatment for hormonal imbalance.

**The resulting claim** — The patient sued the gynecologic surgeon for lack of informed consent and unnecessary surgery.

**The outcome of the claim** — A trial court returned a verdict for the plaintiff that was reversed on appeal. Pivotal to the reversal was the plaintiff's testimony that she and the defendant had discussed the risks associated with total hysterectomy. The surgeon had noted the discussion in the patient's chart. The surgeon denied that the patient had told him to leave her ovaries in place.

## Case #3

### Presenting complaint and initial diagnosis

— While on vacation, a 65-year-old man fell and suffered a comminuted Colles' fracture of his right arm and wrist. It was set in a cast, and he was advised to return home for follow-up care. Four days later, he consulted an orthopedic surgeon.

**The case in brief** — The orthopedic surgeon found that the fracture fragments had collapsed and there was poor alignment. The surgeon recommended pinning the arm fracture and placing an external fixator to correct the wrist injury. He told the patient that unless corrective action was taken immediately, the arm would remain extremely deformed. The patient reluctantly agreed to the surgery. Following the operation, he complained of extreme pain, and adjustments were made to the screws in the external fixator. After surgery, he suffered numbness and weakness in his hand.

**The resulting claim** — The patient sued the orthopedic surgeon for negligence, alleging that he had violated the standard of care in performing the surgery. Experts testified that nerve injury occurred during pin placement.

**The outcome of the claim** — The case was settled. Although lack of informed consent was not alleged, it was a factor in the decision to settle. Despite signing a consent form, the plaintiff in a deposition said the surgeon had not warned him of the risks or potential complications of the pinning procedure. The surgeon said he had told the patient of the possibility of nerve damage during the pinning procedure, but he did not discuss alternatives that he believed to be more risky. The patient's chart did not document the informed consent discussion, making it impossible to counter the patient's statements.

**The points these cases make** — Failure to obtain informed consent can lead to malpractice claims and is often a secondary issue in a complaint.

"In these cases, the patients did not fully understand the procedure that was done or comprehend the associated risks," said Alfred J. Clementi, M.D., an Arlington Heights surgeon and member of the Illinois State Medical Insurance Services Board of Directors.

Physicians, orthopedists in particular, should never promise that the patient will return to 100-percent normality after a surgical procedure, he said. There is almost always some residual effect, such as limitation of limb movement, especially with older patients.

Dr. Clementi advised that obtaining informed consent need not be difficult. It should be done to avert legal problems and because it is good medicine.

Consider the patient's ability to under-

## ISMIE seeks return of 195 tapes

For nearly a decade the Exchange's risk management department has provided a variety of videotapes for loan to physicians. Unfortunately, some borrowers have taken nearly that long to return them. Currently, 195 tapes are on what seems to be permanent loan, and the Exchange urges their return.

The most popular videotape, "Managing Your Risk in the Office/At the Hospital," is part of the self-study program worth six hours of AMA/PRA Category 1 credit. Stock for this tape is especially low, with a resulting month-long waiting period.

The Exchange will contact procrastinating borrowers by mail in the next few weeks. If you have an ISMIE videotape you've been meaning to return, now is the time to do it. Mail them to the Exchange's risk management department, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

stand the information you want to relay, he said. "If a patient is just coming out of anesthesia, speaks another language, or is older and doesn't hear well, communicating the necessary information will be more difficult. Effective communication may require help from a family member. Explain in a caring manner and try to empathize with the patient. Don't just say, 'You have cancer and that breast must come off.'

"Patients may forget as much as 60 percent of what a physician tells them," Dr. Clementi said, adding that anxious patients have particular difficulty absorbing the doctor's advice. He suggests the following six steps for talking to patients:

1. Explain the problem and your recommendations.
2. List the most common complications and the most serious risks. It is not necessary or advisable to list every possible complication.
3. Describe alternatives, including no treatment.
4. Make sure the patient understands. Get some feedback. Ask patients to repeat what you tell them or ask if they understand the procedures, the associated risks and complications, and the alternatives.
5. Give the patient the opportunity to make a choice, but at the same time explain why that choice may be a poor one.
6. In the chart, document that informed consent has been obtained. This should include a statement that is personalized to the specific situation, that notes that the procedure, including alternatives, risks and complications, was discussed with the patient, and that the patient understood and agreed to it. ■

Carol Brierly Golin is publisher of Medical Liability Monitor.

## EXCHANGE Q & A

**Q: When should I notify the Exchange of changes I want made on my renewal policy?**

**A:** As soon as you become aware of any changes in your practice, notify the Exchange's Underwriting Division in writing. You may do this any time before the renewal date. To request change forms, call Underwriting at (312) 782-1654 or (800) 782-ISMS.

**Q: I occasionally send a letter requesting policy changes with my premium payment. Is this acceptable?**

**A:** For quicker, more efficient service, correspondence and premium payments should be mailed separately, since payments are directed to a bank lockbox. If you do send correspondence with a payment, it will be routed to ISMIE underwriters, but the processing of your request will be delayed. Send policy change requests directly to the Exchange Underwriting Division, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

**Q: What is a companion endorsement?**

**A:** Policy endorsements are statements that are added to a basic policy, address individual insurance needs, and may clarify or restrict coverage. Physician employers can be held responsible for their employees' acts or omissions. As a result, companion endorsements are sometimes necessary. These are policy endorsements that appear on employers' policies if an employee has a restriction on his or her policy. If a claim or suit arises from an employee's performance of a prohibited procedure, the companion endorsement prevents the employer's policy from responding. With a companion endorsement in conjunction with an employee restrictive endorsement, neither the employee nor the employer is covered for a prohibited procedure.



## GUEST EDITORIAL

## Take the time – write it down

In October 1991, I tried one of the strangest cases of my 17 years as a trial lawyer. An avid golfer sued my client, an orthopedic surgeon, for breach of contract and breach of warranty stemming from his elbow surgery. In particular, the golfer claimed that my client promised that he would golf without pain, with a stronger arm and with a lower handicap within six weeks after the elbow surgery.

As absurd as I thought the case was, it was particularly worrisome. Since it was an oral contract case, the court excluded my expert on the medical issues. The contract debate centered on the question of whether the patient or the physician was more believable, and the existence and terms of an oral contract. My client was a good doctor and a good witness, but the plaintiff ran a successful car leasing business. He obviously spent a substantial amount of time selling himself and his business to the public.

*The records should be complete when the patient is seen and treated. Any attempt to alter them will only make a case look and smell like a cover-up.*

At trial we attacked the plaintiff on a number of grounds, including his claimed damages. We subpoenaed his country club and district golf association records. Through the records we proved that he had played the same number of rounds the year after the surgery as he had played the year before it; that his handicap decreased after the surgery; that he traveled to Florida and Hawaii on golf vacations after the surgery; and that he even played with Arnold Palmer after the surgery.

To support my client's testimony, we used a 4-foot by 6-foot blowup of his office records. Almost three weeks before the surgery, my client noted in his office records that he had explained to the plaintiff that there might be some residual pain and discomfort after the elbow surgery.

The jury deliberated briefly and returned a verdict in favor of my client. A number of jurors later told me they found it particularly convincing that my client's records contained such a simple, straightforward notation of the warning to the plaintiff concerning potential postoperative prob-

lems. They told me that the notation not only refuted the plaintiff's testimony but also was consistent with their personal experience with physicians. The obvious lesson was that my client's complete office records helped us win the case.

Good medical records can also prevent a case from being filed. An easy example is a gastroplasty for morbid obesity. These surgeries are known to create complications such as wound infections, obstructed stomas and incidental splenectomies. If a complication occurs, the patient is likely to ask his or her lawyer about filing a malpractice case against the surgeon.

The lawyer will probably subpoena the surgeon's records. It is helpful to the defense if the records state that the surgeon explained the risks, benefits and possible complications of the surgery to the patient. In this situation, the patient's lawyer may doubt the credibility of his own client if he or she tells the lawyer that the surgeon never discussed the risks of surgery. Indeed, the patient's lawyer will probably think twice before filing a lawsuit. Similarly, the lawyer's medical consultant will think long and hard before signing an affidavit supporting the patient's case.

Most good plaintiff's lawyers are good trial lawyers and good business lawyers. They do not want to take a case unless there is a strong chance of recovery. As in the automobile case in which the only witness says that the plaintiff ran a stop sign, lawyers do not want to invest time and money in medical cases when the medical records support the physician.

Unfortunately, I cannot cite statistics showing the number of cases that are not filed because a physician has thorough medical records. I can cite, however, those cases that are lost, in part, because the defendant physician does not have detailed records.

I lost a dental malpractice case in which my client had only portions of his patient's records. He testified that his records had been damaged or lost in a flood. The jury later told me that those missing records greatly affected their attitude about his credibility and the dental treatment he rendered.

In the courtroom, altered records can be just as damaging as missing records. My partner tried a case in which his client testified at trial that she had changed portions of the records after she was sued. She had not disclosed this previously to my partner or anyone else. She followed this surprising testimony by adding that only some of her records could be believed. A defensible case with good defense experts became a multi-million dollar verdict for the patient.

Medical issues in malpractice suits are often difficult to understand and defend. There is no sense in making the case into a

soap opera. The records should be complete when the patient is seen and treated. Any attempt to alter them will only make a case look and smell like a cover-up.

I truly enjoy my career as a trial lawyer, but I assume that most doctors do not share my enthusiasm for the courtroom. The easiest way to avoid it is to keep comprehensive records noting complaints, history, diagnosis, and recommended tests, as well as patient discussions about recommendations and

potential risks, benefits and complications of medical care. You don't need to write a novel about each contact with the patient. It does not take much time or effort to make the appropriate notations (or even abbreviations) in a chart. The few seconds spent on documentation can save countless hours in a lawyer's office or weeks in a courtroom as a defendant in a malpractice case. ■

## Documentation is the focus of new office staff seminars

**PERSONNEL:** The Exchange continues seminars to educate medical office staff on reducing liability. By Anna Brown

[ CHICAGO ] In August, the Illinois State Medical Inter-Insurance Exchange will begin a new series of seminars for physicians' office staffs. The Exchange will host 24 seminars through December throughout the state, focusing on recognizing problems in documentation and medical record maintenance.

"We had an overwhelmingly positive response to our last series of office staff seminars," said Jere E. Freidheim, M.D., chairman of the Exchange Risk Management Committee. "Since medical office staffs are physicians' first line of defense in reducing the risk of malpractice claims, physicians need to make sure staffs are not also the cause of claims. By teaching effective risk management procedures, the Exchange hopes to help physicians and their staffs work together to recognize areas of liability risk."

The two-hour seminars are open to office managers, nurses, receptionists, business managers and all other medi-

cal office personnel. Physicians are also invited to attend. Participants will learn general principles of medical record documentation, the importance of maintaining confidentiality, management of non-compliant patients, effective documentation of telephone calls, and proper patient follow-up.

Within the next few weeks, ISMIE insureds will receive a brochure in the mail titled "Documentation: An Essential Office Practice" that describes the new seminars and offers registration information. Early registration is recommended, as space is limited.

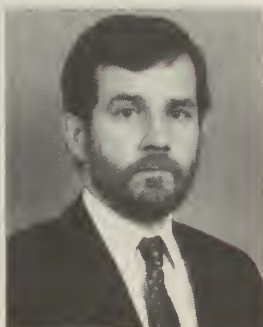
Registration is by mail only. To register, send a check or money order for \$10 payable to ISMIE to the Illinois State Medical Inter-Insurance Exchange, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. For more information, call the risk management department at (312) 782-2749 or (800) 782-ISMS. ■

## Documentation: An Essential Office Practice

## Dates, times and locations of seminars

Date	Time	City and facility
Aug. 26	8:30 a.m. & 1:00 p.m.	Chicago; University Club
Aug. 27	8:30 a.m.	Matteson; Holiday Inn
Sept. 2	8:30 a.m.	Oak Lawn; Holiday Inn
Sept. 9	8:30 a.m. & 1:00 p.m.	Oak Brook; Marriott
Sept. 10	8:30 a.m.	Joliet; Holiday Inn
Sept. 23	8:30 a.m. & 1:00 p.m.	Peoria; Jumers
Sept. 30	8:30 a.m.	Carbondale; Knights Inn
Oct. 1	8:30 a.m.	Mt. Vernon; Holiday Inn
Oct. 1	8:30 a.m.	Springfield; St. John's Hospital
Oct. 7	1:00 p.m.	Moline; United Medical Center
Oct. 8	8:30 a.m.	Rockford; Clock Tower Inn
Oct. 14	8:30 a.m.	Geneva; Riverwalk Restaurant
Oct. 22	8:30 a.m.	Collinsville; Holiday Inn
Oct. 28	8:30 a.m. & 1:00 p.m.	Oak Brook; Marriott
Oct. 29	8:30 a.m. & 1:00 p.m.	Chicago; University Club
Nov. 5	8:30 a.m. & 1:00 p.m.	Rosemont; Holiday Inn O'Hare
Nov. 12	8:30 a.m.	Bloomington; Jumers
Nov. 18	8:30 a.m.	Gurnee; Holiday Inn

Each seminar will last two hours. If you have any questions, please call the ISMIE risk management department at (312) 782-2749 or (800) 782-ISMS.



**William J. Rogers** is an Illinois State Medical Inter-Insurance Exchange trial lawyer with the Chicago firm Bollinger, Ruberry and Garvey. He lives in Wilmette.



ONE PHYSICIAN'S STORY

# Bataan reunion recalls Death March memories

*Adriano S. Olivar, M.D., a Philippine-born Flossmoor clinical pathologist, was among the U.S. and Filipino troops that surrendered to the Japanese in April 1942. After 50 years, he returned to the site where he and his fellow prisoners began their deadly 65-mile trek.*

BY ANNA BROWN

**"H**ow did I ever do it? How did we do it?" asked Adriano S. Olivar, M.D., as he recalled his experiences as a young Filipino soldier just out of high school. Dr. Olivar was among 78,000 U.S. and Filipino soldiers who were stationed in the Philippine region of Luzon and were defeated by Japanese troops on the Bataan peninsula during World War II.

In April, Dr. Olivar returned to Bataan for a reunion held by the American Defenders of Bataan and Corregidor to commemorate the 50th anniversary of the fall of Bataan. On April 9, 1942, Dr. Olivar and his fellow prisoners of war began a forced trek from the southern tip of the peninsula to a concentration camp 65 miles north. With little food and water, the soldiers made what is now referred to as the Bataan Death March.

Dr. Olivar says many of the men who fought in Bataan are still unable to talk about their painful experiences, even after 50 years.

In the 1970s, the Flossmoor clinical pathologist wrote a series of articles for the local newspaper detailing his Death March experience and life as a prisoner of war. Recently he spoke with *Illinois Medicine* about his ordeal on Bataan.

IN EARLY 1942, when he was 17, Dr. Olivar registered for military service despite being underage and was sent to Luzon. Filipino troops were incorporated into the U.S. Army, and Dr. Olivar served as a sergeant in

the 31st Division under the command of Gen. Douglas MacArthur.

"When the Japanese landed in the Philippines after Pearl Harbor, they began pushing us back. We couldn't stop them," he said. "The Orange Plan, under Gen. [Jonathan Mayhew] Wainwright, called for us to retreat into Bataan and wait for help. We were doomed, because the Navy was completely destroyed at Pearl Harbor. We fought hard, but we were sick and out of ammunition and food."

While fighting in the jungle that January, Dr. Olivar was shot in the leg. The leg was amputated, and he recuperated in an open-air jungle hospital before the surrender. As the Japanese advanced on Bataan, it became obvious that something was going to happen.

In an article for the Flossmoor *Star-Tribune*, Dr. Olivar recounted: *About a week before the surrender of Bataan, there was a drastic and markedly noticeable change in activity. When the Japanese opened their final offensive on April 3, it was apparent that our lines were being hit, and hit hard. Lying on my bed, I was gripped by the awful thought of the*



Adriano S. Olivar, M.D., (front row, right) survived the Bataan Death March in 1942 and eventually escaped from the Philippines on a U.S. submarine. He is shown with fellow soldiers arriving in Papua New Guinea in 1945.



## ONE PHYSICIAN'S STORY

*carnage that my comrades, both American and Filipino, were being subjected to on the front lines.*

Within days, the Americans and Filipinos on Bataan were defeated and forced into the grueling march in which 14,000 soldiers died. The Japanese had expected to find only 30,000 troops and had provided 230 trucks to transport prisoners to the concentration camps. What they found were 64,000 Filipinos and 12,000 Americans, most of whom were sick with malaria or dysentery, or near starvation.

Dr. Olivar began the march with the intent of escaping, he said. He formed a group of 11 amputees who were with him in the hospital, and they marched — keeping, by necessity, well behind the others. He says they were left to march in relative peace.

*All during the morning of the day following the surrender, we made the necessary provisions to leave the hospital shortly after noon, Dr. Olivar wrote in the Star-Tribune. We padded the tops of our crutches with cotton and bandages. Each of us also decided to take the woolen blanket from our bed so we would have something to lie on at night. Other than woolen pajamas, which had not been changed for at least a week, we had no clothing.*

As Dr. Olivar related, only three of the 11 amputees arrived safely at Camp O'Donnell, the concentration camp where they would remain for three months. "The others gave up on the second day of the march, too weak to continue. They were shot and thrown in a ditch. That I survived is something to thank the Lord for."

The three remained together at the camp until Dr. Olivar was transferred to a Manila hospital. "I never got the chance to get in touch with them since," he said.

**ON THEIR THREE-DAY MARCH,** Dr. Olivar and the other soldiers, as well as thousands of civilian refugees, were denied food and water as they shuffled along in heat that reached 100 degrees or more in the shade. Before the march, soldiers' diets consisted of less than 1,000 calories a day, as supplies were extremely low. On the first day, Dr. Olivar saved half his daily ration, only to have it stolen by a starving prisoner that night.

Fatigue and despair mounted as they marched from town to town. Dr. Olivar said his hopes would return briefly with reports of civilian efforts to help prisoners escape. At one point, he

noticed a crack in his wooden crutch and knew he would not survive if the crutch broke. He wrote:

*Without any prearranged instructions, we automatically divided ourselves into two groups, the "toddlers" and the "slow walkers." The toddlers consisted of amputees who learned to use crutches on the day of the surrender, and the slow walkers were those who had from a week to two months' experience. The former group was composed of virtually bed-patients who were very weak and had bleeding stumps. I attached myself to the latter group despite my draining stump. Two of the stronger boys elected to stay with the toddlers in case they needed extra help. It was sort of the "maimed carrying the lame."*

As they crept along, faster moving groups of prisoners would pass, led by Japanese soldiers on bicycles. Dr. Olivar says the dust kicked up by the marchers added considerably to their misery. Since the island of Corregidor

had not yet been captured, Japanese artillery was sent in the opposite direction of the march, and the prisoners were greatly frustrated that they could not warn the defenders on the island of the impending offensive.

"At this point," he wrote, "Japanese soldiers riding on trucks discovered a new game. They would stick a piece of wood or their rifle butts out of the trucks as they



**Sgt. Olivar, (left) and Col. Nicanor Jimenez served together in the 31st Division of the U.S. Army during WWII. Both received medals of honor during the Bataan reunion.**

passed us. Marching prisoners of war were falling down by the roadside like dominoes."

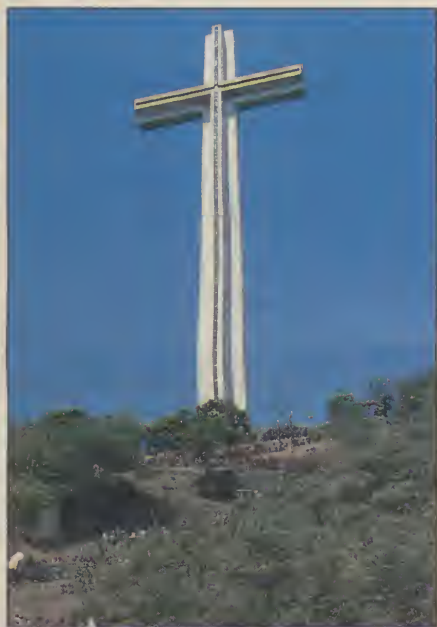
Eventually, Dr. Olivar's group was picked up by Japanese trucks and driven to the San Fernando railway, which then took them to Camp O'Donnell. He recounts that prisoners were packed into the rail cars, whose floors were covered with cow dung. Many prisoners died on that train journey, he said.

He celebrated his 18th birthday at the camp. He said although their captors governed their every activity, when the rainy season began all the prisoners ran out rejoicing and dancing in the water. The Japanese could do nothing but look on, unable to subdue their merri-ment.

After three months at Camp O'Donnell where, unlike the more hale prisoners, he was not forced to work, Dr. Olivar was transferred to a hospital in Manila. By the time he arrived there, the Japanese government had established Filipino puppet governors in various regions. Through his governor, who was a relative, he was allowed to return to his hometown, 300 miles south of Manila. From there, he left the Philippines on a U.S. submarine bound for Australia. He did not return until the islands were liberated in May of 1945.

**WHEN HE RETURNED TO** Bataan for the first time since the war, Dr. Olivar saw the places where he had fought and surrendered. Much of the jungle has disappeared, he said, and many places were hard to recognize, but many were still vivid in his mind, such as the place

*(Continued on page 14)*



**Dr. Olivar and the soldiers who reunited this spring in Bataan placed wreaths at the base of this monument commemorating those who fought and died on the peninsula. Then-Philippine President Corzon Aquino and the U.S. ambassador attended the ceremonies.**



**War-torn structures such as this still stand untouched after 50 years on the island of Corregidor off the Bataan coast. While Bataan fell in April 1942, U.S. and Filipino soldiers on Corregidor held off the Japanese for another month.**



# Dorothy Freeston is July Employee of the Month

**EMPLOYEE:** A "kind and caring individual" receives this month's honor. By Kevin O'Brien

[ CHICAGO ] Dorothy Freeston, membership coordinator in the Illinois State Medical Society's Specialty Societies Division, is the ISMS Employee of the Month for July.

Freeston is responsible for the day-to-

day administration of membership services for 11 medical specialty societies, each with different requirements and totaling more than 10,000 physicians. She also assists in publishing six annual directories.

"Dorothy is consistently developing innovative ideas to facilitate membership operations and to recruit new members," said ISMS Deputy Executive Vice President Richard A. Ott, who presented the award. "Her suggestions are respected by the entire staff. When she has an idea that will improve a policy or procedure on the national level, she takes the initiative to contact the appropriate society. Often her suggestions are adopted by the national society."

Ott said Freeston shines in one particularly vital area. The Illinois Psychiatric Society provides a physician referral service through the Specialty Societies Division, and the responsibility for handling these referrals falls to Freeston. "It is a task that requires sensitivity, compassion, patience and, most important, a good listener," said Ott. "Dorothy is all that and more. She has helped innumerable people, never showing disdain for their needs. As a result, Illinois psychiatrists – and indeed all physicians – benefit because of the efforts of this kind and caring individual who represents them to the public."

Freeston received a plaque and a check for \$200 during a presentation July 6 in the Society's Chicago offices. In addition, her name will be inscribed on a plaque in the ISMS reception area listing each Employee of the Month.

"I would like to thank the people who submitted my name as a nominee and the committee, who thought I was deserving of this honor. And I especially



Dorothy Freeston, membership coordinator in ISMS' Specialty Societies Division, is July's Employee of the Month.

would like to thank my division – Specialty Societies – who contributed to the support of this honor," said Freeston.

Freeston joined the former Illinois Foundation for Medical Care as a secretary in 1974 and transferred to the ISMS Specialty Societies Division when the foundation ceased operation. She was promoted to membership coordinator in May 1992.

"Our physicians, too, know Dorothy's value," concluded Ott. "She regularly receives warm notes of thanks from them. By almost any standard, Dorothy Freeston consistently provides a wonderful example of what it means to be an ISMS Employee of the Month."

All permanent, full-time ISMS/ISMIS employees – except those at senior management level – are eligible for the Employee of the Month award. Physicians who wish to nominate a staff member for the award should call the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■

## YOCON<sup>®</sup> YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

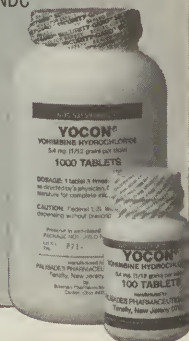
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## Bataan reunion recalls Death March memories

(Continued from page 13)

where he lost his leg. He also found a place where he knew he had slept on the march.

With the American Defenders of Bataan and Corregidor, Dr. Olivar was greeted by the U.S. ambassador to the Philippines and then-President Corazon Aquino. The Defenders meet every year to commemorate their war experiences, but this year marked their first reunion in Bataan. The ambassador presented each veteran a medal of honor, and wreaths were laid at the base of the memorial honoring Americans and Filipinos who fought and died on Bataan.

"I compared notes with the American soldiers," Dr. Olivar said. "They are still having nightmares, and many can't talk about it. Every now and then I have unpleasant nightmarish feelings, but I say, 'I survived.'"

"On the way back to the site of the march, those feelings returned," he said.

Dr. Olivar said he owes his medical career – at least in part – to his experiences on Bataan: "The medical profession saved my life. It definitely had a bearing on my decision."

After the war, Dr. Olivar attended the University of the Philippines, received his medical degree, and interned at a hospital in Hartford, Conn. He came to Chicago to complete his residency in pathology at Northwestern University, where he later became a full-time faculty member. He has retired from active practice but maintains his ties with Northwestern as an associate in pathology.

Remembering his youth during the war, he said, "Everything was a struggle all the way." But now he can laugh a little as he says, "You know what they say, 'Only the good die young.'"



# ADA requires changes in physician-employee relations

**EMPLOYMENT:** Physicians must consider two perspectives when reviewing their compliance with the employment provisions of the Americans with Disabilities Act. By Kevin O'Brien

Just as the Americans with Disabilities Act mandates access to existing and newly constructed facilities and programs and services for people with disabilities, it also affects all areas of the physician-employee relationship.

"There are two perspectives physicians must consider when complying with the ADA," said Joseph E. Tilson, a partner with the law firm Katten Muchin & Zavis. "One is the perspective of an employer of clerical and other employees. And two is the perspective of treating patients with disabilities who are employed by others."

Tilson said that Title I of the ADA requires all U.S. employers – not just physicians – to accommodate employees with disabilities in such areas as hiring and termination; flexible scheduling, including time off from work for physical therapy or other medical treatments connected to their disability; appropriate job-shifting; and the provision of special equipment or other aids to permit employees to perform necessary job functions.

Beginning July 26, practices with 25 employees or more are required to meet the employment provisions contained in Title I of the Act. The deadline for practices of 15 to 24 employees to comply

with the employment provisions will be July 26, 1994. Physician practices with fewer than 15 employees need not comply with Title I provisions. Tilson suggests that physicians review their personnel policies and procedures in several areas to ensure compliance.

**"TITLE I PROTECTS** any 'qualified individual with a disability,' meaning any individu-

al who, with or without reasonable accommodation, can perform the 'essential functions' of the job in question," said Tilson. Determining a job's essential functions is left to the employer, but Tilson advised physicians to prepare a "written description before advertising or interviewing applicants for the job." That way, he said, the physician will be able to provide valid evidence of the

job's essential provisions.

Physicians must take care not to discriminate in job application procedures, hiring and termination, compensation and benefits, advancement, job training, and "other terms, conditions and privileges of employment," according to the Act. Physicians cannot segregate their disabled employees from other employees, nor can they participate in contractual relationships that in effect discriminate against people with disabilities.

Nor can a physician discriminate against a non-disabled person who associates with a disabled person, said Tilson. "For example, according to the

(Continued on page 21)

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## Seek further advice on ADA compliance

The comprehensiveness of the Americans with Disabilities Act makes it impossible to fully explain every provision with which physicians must become familiar, even in a multi-part series. For more information on compliance, the American Medical Association and the Illinois State Medical Society urge physicians to contact the following agencies:

- The U.S. Justice Department Office of ADA, at (202) 514-0301, provides information on the public accommodations requirements.
- The Equal Employment Opportunity Commission, at (800) 669-3362, offers information on the employment provisions.
- The Architectural and Transportation Barriers Compliance Board also publishes compliance guidelines for public accommodations. The non-profit group can be reached at (800) USA-ABLE.

Several other private companies and legal firms also specialize in ADA compliance issues. In addition, the AMA's House of Delegates passed a resolution at its June annual meeting calling on the AMA to study the Act's impact on physicians' practices and their provision of health care to patients, and to "provide appropriate guidance to physicians on the interpretation and implementation of the Americans with Disabilities Act as expeditiously as possible." ■

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# Reform consensus still at least a year away

**AMA FORUM:** Despite several proposals in Congress, significant national health care reform will not occur in this election year, D.C. insiders say. By Tamara Strom

[ CHICAGO ] Drawing the ire of supporters of the American Medical Association's Health Access America plan, an influential congressman and a member of the Bush administration both said any national action on health care reform is at least a year away. The remarks were made by U.S. Rep. Fortney "Pete" Stark (D-Calif.) and Tom Scully, a Bush aide who co-authored the president's reform plan, during a two-hour health care forum at the AMA's annual meeting in June. The panel also included representatives from California, Minnesota and Vermont, states that are pressing ahead with their own reform plans.

Stark and Scully agreed that while public sentiment for health care reform is increasing, the likelihood of Congress's passing and the president's signing reform legislation this year is slim.

"The political climate is not there," Scully said. "Everyone wants universal access, but it's very complicated." Stark said when he "peers into his crystal ball" he doesn't see passage of the AMA's



From left: U.S. Rep. Fortney "Pete" Stark (D-Calif.); AMA Executive Vice President James S. Todd, M.D.; AMA Speaker of the House Daniel H. Johnson Jr., M.D., and Bush administration aide Tom Scully participate in the AMA's Forum on Health Care Reform.

Health Access America, Bush's market-based plan, or the bill he himself sponsored with House Majority Leader Richard Gephardt (D-Mo.).

Because no single plan has the two-thirds majority needed to override a presidential veto, Stark said passing

health care reform legislation will require a bipartisan effort. Any plan passed in the future will result from negotiations, he predicted, emphasizing that organized medicine must be part of that coalition.

Stark also said reduction of double-digit inflation for health care is a necessary component of reforming the system. The United States annually spends more than \$800 billion on health care, he said. The country could save billions of dollars for the first year "if we bring the rate of health care inflation down to the regular rate of inflation," he claimed. "That buys a lot of access."

In fact, Stark said, the major deficiencies in the AMA's Health Access America plan are the lack of universal access and the absence of cost containment mechanisms. "Your plan scores zip on cost containment," he told the physician audience.

Stark added that as he read the resolutions being considered by the House of Delegates, he was struck by the number of proposals aimed at putting cost con-

tainment controls on non-MDs. "Non-MDs are the scapegoats in these resolutions," he said. Physicians must "do their part" to contain costs, he added.

Scully said that although the administration views Health Access America's call for employer-mandated insurance coverage for workers as a "regressive tax," he doesn't think the two sides are "that far apart; we've worked things out in the past."

"This thing has to boil up to where people get angry," Scully said, adding he is "not pessimistic" about some type of health care reform's passing next year. ■

## AMA tackles public health issues

The following are further highlights from the American Medical Association's annual meeting.

### Illinois delegate combats eating disorders

Illinois delegate Ulrich F. Danckers, M.D., successfully introduced Resolution 417, which addressed eating disorders. The resolution cited overemphasis on losing weight as being as dangerous to good health as obesity is, and the House of Delegates agreed.

### Report outlines adolescent confidentiality

Calling confidential care for adolescents critical to their health, the House of Delegates adopted Report A, which recommended several ways to provide and maintain young adults' privacy in health care.

Although some delegates voiced concern over parents' diminishing role in adolescent health care, the House concluded that patient confidentiality for teens is crucial. The report encouraged physicians to involve parents in their children's medical care except when such involvement would not benefit the patient. Delegates emphasized that parental consent should not impede adolescents' access to health care. ■

### HIV, TB reports draw praise

Two reports drafted by the AMA Board of Trustees were highly praised and adopted by the House of Delegates. Report BB focused on HIV infection in the health care setting, and Report OO addressed the multifaceted risks of treating multiple-drug-resistant tuberculosis.

Report BB is now the AMA's complete

policy on HIV and physicians. The report reaffirmed the recently completed recommendations of Gov. Jim Edgar's Task Force on AIDS in Health Care and existing Illinois law allowing physicians to test for HIV infection without written consent from patients. Such testing is common practice for other communicable diseases.

Other recommendations in Report BB included the formation of a panel of experts to create a statement on transmission risks from available look-back information; pretest and post-test counseling for routine HIV testing; physician disclosure of HIV seropositivity to a state health official or review committee; and the continuation of the AMA education campaign on the extremely small risk of HIV transmission from health care worker to patient.

Recommendations in Report OO included routine TB testing of HIV-infected patients; the linking of HIV and TB reporting; aggressive contact tracing; tuberculin skin testing for all health care workers upon employment; and increased federal funding for TB control and research. ■

### Recertification

The importance of specialty recertification was scrutinized during extensive and divided House debate and reference committee testimony. Several resolutions and reports questioned the validity of recertification, raising the issue of whether current data was sufficient to link recertification to quality of care.

The House finally adopted a report from the Council on Medical Education recommending that the AMA encourage the American Board of Medical Specialties and its member boards to "continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification." In addition, the report recommends that the "holder of a certificate without time limits, should not be required to seek recertification."

But several speakers expressed concerns that such action would discriminate against physicians with time-limited certificates. Speakers supporting recertification said that with advances in medicine, examinations prove physicians' qualifications to the public. "Records don't lie," said Illinois delegate Lawrence L. Hirsch, M.D., from Northbrook.

Also adopted by the House were Council on Medical Education reports recommending "that the AMA continue to work with other medical organizations to educate the profession and public about the board certification process" and that the AMA encourage specialty boards issuing time-limited certificates to include young physicians in the decision-making process. ■

Delegates referred to the Board of Trustees a Council on Medical Education report on revisions to the AMA's Physician Recognition Award to further discuss the conflicting testimony heard in House and reference committee debate. Testimony was equally divided regarding mandatory reporting of AMA PRA Category 2 activities. Some speakers supported the revisions if credit was permitted for specialty board recertification, but opposed them if reading was not allowed for PRA credit. ■

### Physician Recognition Award

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By Anna Brown, Kathy Meyer and Tamara Strom

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# What is the physician's role in health care reform?



**Manuel Malicay, M.D.**  
Internist, Oak Brook

I strongly believe that the role of the physician is to be an advocate for patients. We should do everything we can to help patients in terms of health care so that we can cut the costs.

*Interview by Anna Brown*

*Photos by William Daniels/The Photo Partners*



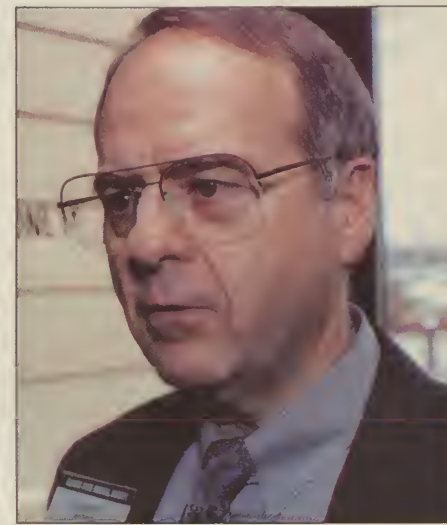
**Ulrich F. Danckers, M.D.**  
Radiologist, River Forest

Physicians should be on the forefront of starting and shaping health care reform. There is no one else who can claim to be a better expert than the physician on this vital matter.



**Ralph R. Velazquez, M.D.**  
Family physician, Rockford

The physician has always been a patient advocate. Many of the decisions being made on health care are being made by people who aren't necessarily patient advocates; they're just looking at the economic issues. We have the greatest scope for this problem.



**Arthur R. Traugott, M.D.**  
Psychiatrist, Urbana

The physician's role in health care reform should be as an active participant. We need representation at every forum where the matter is being discussed so that physicians' ideas and thoughts can be part of the compromise plan for what is needed for national health care.

## Illinois physicians represent their colleagues at the AMA

*(Continued from page 1)*

Medical Society analysis handbook, developed by delegation members before the start of each AMA House of Delegates' annual and interim meeting, as one of the tools contributing to their effectiveness. Illinois delegates report that the book is unique and indispensable, so much so that delegates from other states often ask to look at it.

The delegation uses its analysis for reference committee discussion and testimony on each resolution under consideration by the House. The reference committee, a panel of five delegates, may recommend to the House that a resolution be adopted, not adopted, amended by substitution or editorially amended. Reference committee reports become the working documents of every annual or interim meeting.

Membership on reference committees is a coveted honor, and with the recent selections of Illinois physicians to serve as reference committee members and chairs, the AMA leadership has recognized Illinois' expertise at building consensus. During the 1991 interim meeting in December, Ronald G. Welch, M.D., a neurologist from Belleville, chaired Reference Committee A, which researched 12 recommendations for correcting RBRVS, the new Medicare physician payment system, among other items. The June annual meeting saw Robert M. Vanecko, M.D., a thoracic surgeon from Chicago, chair the reference committee that considered issues relating to medical practice and facilities.

In addition, Harold L. Jensen, M.D., an internist from Harvey, served as a member of the Constitution and Bylaws reference committee. ISMS President-elect Arthur R. Traugott, M.D., an Urbana psychiatrist, was appointed to the Rules and Credentials Committee.

Dr. Welch said the delegation uses its issue research and analysis to build consensus among delegates. "Quite frankly,

many times we're in the minority, and sometimes we are able to turn the consensus around, based upon the fact we're able to bring up things people may not have known."

*"Many times we're in the minority, and sometimes we are able to turn the consensus around, based upon the fact we're able to bring up things people may not have known."*

**RONALD G. WELCH, M.D.**

At the June annual meeting, Dr. Seward said the Illinois delegation was especially effective in presenting testimony in reference committees on the issue of health care reform. "Illinois had tremendous input into those reference committees and, subsequently, to the final resolutions that came out giving directions on where we want to go with health care reform," he said.

**THE ENTIRE DELEGATION** to the AMA House serves twice a year — in June at the annual meeting and again in December at the interim meeting — but several Illinois physicians perform ongoing duty as members of AMA councils. The various councils review the spectrum of issues confronting physicians and make policy recommendations to both the Board of Trustees and the House of Delegates.

Dr. Seward hailed Dr. Welch's recent appointment to the Council on Legislation as a plus for both Illinois and the AMA. Illinois AMA Delegation Chair-

man Alfred J. Clementi, M.D., a general surgeon from Arlington Heights, serves on the Council on Long Range Planning and Development. "Dr. Clementi is one of the senior people on that council," said Dr. Seward, "so his input is listened to."

One of the most influential councils is the Council on Ethical and Judicial Affairs. "If anything," said Dr. Seward, "I would say that during the next decade, ethics are going to be a major issue." Representing Illinois on this key council is former ISMS Board of Trustees Chairman George T. Wilkins Jr., M.D., an Edwardsville pediatrician.

Because of the nature of the issues coming before it, CEJA is the only council whose pronouncements serve as official AMA policy.

**THE STATE'S EFFECTIVENESS** is also exemplified by the level of participation on the AMA Board of Trustees. Dr. Seward is in his third year of his first three-year term as a member of the board. Moreover, this year's annual meeting saw Illinois family physician John J. Ring, M.D., of Mundelein, complete his term as AMA president, following a two-year term as chairman of the AMA's Board of Trustees. Dr. Ring has often proudly noted that he is a "product of the Illinois House of Delegates."

Finally, several Illinois students have served on the AMA board and on councils. Scott L. Bernstein, M.D., formerly of Urbana, just completed a term as the student representative on the board. Deidre K. Spicer, M.D., formerly from Evanston, served as a student member of the Council on Medical Service, and Allison August served as a student member of the Council on Ethical and Judicial Affairs. ■

## OBITUARIES

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

\*Godwin

Melvin C. Godwin, M.D., of San Marcos, TX (formerly of Chicago), died October 26, 1991 at the age of 82. Dr. Godwin was a 1948 graduate of the Loyola University Stritch School of Medicine, Maywood.

\*\*Roque

Francisco T. Roque, M.D., of Deerfield, died October 11, 1991 at the age of 86. Dr. Roque was a 1932 graduate of Rush Medical College, Chicago.

\*\*Shultz

Gordon H. Shultz, M.D., of Heyworth, died October 19, 1991 at the age of 85. Dr. Shultz was a 1934 graduate of Loyola University Stritch School of Medicine, Maywood.

\*Stackable

William R. Stackable, M.D., of Centralia, died December 13, 1991 at the age of 67. Dr. Stackable was a 1948 graduate of the University of Illinois College of Medicine, Chicago.

\*\*Weissmann

Marvin F. Weissmann, M.D., of Hampton, died December 14, 1991 at the age of 84. Dr. Weissmann was a 1934 graduate of the University of Cincinnati College of Medicine, Cincinnati, Oh.

\*\*Zerbolio

Dominic J. Zerbolio, M.D., of Benld, died October 8, 1991 at the age of 91. Dr. Zerbolio was a 1925 graduate of Rush Medical College, Chicago.



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## OIG, FBI fraud investigations yielding results

(Continued from page 1)

tion, the Illinois Department of Professional Regulation and the Illinois Department of Public Aid.

"Fraud in the health care industry is extensive and nationwide," said Fred Foreman, U.S. attorney for the Northern District of Illinois, in announcing the indictments June 30. "This type of fraud is costly in terms of both dollars lost by the government, private insurers and American citizens, as well as the severe toll that such unscrupulous health care practices have upon our health care system. The criminal complaints which were filed today charge that the citizens of the Northern District of Illinois have fallen victim to such fraud and other forms of abuse."

Operation Goldpill had been ongoing as part of a larger-scale investigation for 2 1/2 years, OIG Regional Inspector General Michael T. Dyer told *Illinois Medicine*. "The main portion of the investigation involved the undercover work of FBI and inspector general officers who made visits to pharmacies posing as Medicaid patients," Dyer explained.

The pharmacists involved altered many of the prescriptions and billed Medicaid and private insurance companies for the same prescription multiple

times using different patient names. In some instances, prescriptions that were never filled were charged to insurance companies, according to the government. The pharmacists also billed third party payers for brand-name drugs when they had dispensed generic equivalents to the customer, the government alleged.

The second type of fraud identified by the investigation involves the buying back and reselling of prescription drugs by pharmacies, Dyer said. Drug dealers known on the streets as "non-con men" buy prescriptions at rock-bottom prices from pharmacy customers. These dealers traffic only in non-controlled substances because there is "less risk," Dyer said.

According to Dyer, the scam works as follows: Individual Medicaid recipients see four or five physicians a day, collecting prescriptions for various ailments. These "patients" then take the prescriptions to four or five different pharmacies and have them filled. The patients sell the drugs to the non-con men, who in turn sell the drugs back to the pharmacy. The government alleges that the pharmacists resold these drugs to other unsuspecting Medicaid customers.

"In effect, the government would be buying the same drugs over and over," Dyer said, as the druggists redispensed

the drugs to other Medicaid patients. He said the government's aim in curbing this abuse is not only stopping the fraud but protecting the public as well.

"As a careful consumer, you may read the labels of every drug you buy and check the expiration dates carefully," he said. "But when a prescription is filled with the drugs that have been bought back you have no way of maintaining quality. These drugs may have sat in some non-con man's trunk for two weeks."

"Any time drugs get out of the normal chain of distribution, you question the possibility of contamination from exposure to other chemicals or sunlight," he added. "You just don't have the same confidence."

**GREED AND THEFT OF FUNDS** are at the heart of most government fraud investigations, Dyer said. Operation Goldpill encompassed greed and possible patient risk, he noted.

"The actual number of cases that include risk to patients make up a very small percentage of the total fraud cases investigated," Dyer said. "In most cases, the risk is to the taxpayers' funds."

Dyer said the government's anti-fraud efforts have only begun. "We've always devoted substantial assets in the health care fraud area; it certainly is an ongoing effort," he explained. "These health care fraud investigations are part of an increased initiative on the part of the FBI. In the Chicago area, an entire [FBI] squad is devoted to health care fraud." FBI health care fraud task forces also are stationed in Columbus, Ohio, and Detroit, he said.

"It is unusual to have an entire FBI squad and so many agents devoted to health care fraud [in any one area]," Dyer said, adding that the task force's presence was dictated by need and opportunity. The need was the government's estimates that more than \$70 bil-

*"Any time drugs get out of the normal chain of distribution, you question the possibility of contamination from exposure to other chemicals or sunlight. You just don't have the same confidence."*

**OIG REGIONAL INSPECTOR  
GENERAL MICHAEL T. DYER**

lion a year is lost in fraud, and the opportunity was the "disintegration of the Russian empire. Agents who had worked counterintelligence were able to be shifted over" into investigating fraud, he said.

And pharmacists are not the only health professionals with cause for worry. Dyer said he cannot comment on specifics but admitted there are ongoing FBI-OIG investigations involving possible physician fraud. ■

## HHS continues DME crackdown

(Continued from page 1)

pay attention to what forms they are approving."

Whether a physician knowingly approves a fraudulent claim or does so by mistake is unimportant to the government. Certifying payment for a non-medically necessary piece of durable medical equipment represents a "false statement to the government," Dyer said, an action punishable by up to five years in jail and a \$5,000 fine for each fraudulent form a doctor signs. Ultimately, a physician could be excluded from the Medicare system for five to 20 years for committing health care-related fraud, Dyer noted.

Because physicians are busy and often sit down with a stack of claims to sign, Dyer said doctors must not blindly sign these certification forms. Each claim must be assessed individually, he stressed.

Physicians also must resist the pressure from patients and equipment sales representatives to approve non-medically necessary equipment, Dyer said. Sometimes a patient will be contacted by a vendor and receive a strong sales pitch about helpful or convenient equipment, and then ask the doctor to approve payment by Medicare. The government has seen many cases such as those involving "catapult" chairs that help elderly people get out of their seats and four-wheel motorized scooters.

"These items may be nice to have, but they are not medically necessary because the person is still able to get around," Dyer said.

Physicians also should follow up with their patients to assure they actually receive medically necessary equipment approved for payment. Unscrupulous companies sometimes deliver a regular wheelchair to a patient when the doctor approved — and Medicare paid for — a motorized chair, Dyer said. The government also has discovered companies that have been reimbursed for equipment never delivered to a patient.

Physicians also have no control over salespeople who forge doctors' signatures on certification forms. "The salesmen sign the doctor's name without the doctor's knowledge," Dyer said.

The Illinois State Medical Society House of Delegates in April adopted policy drawing attention to the problem of fraudulent DME certification. Delegates said physicians are often asked to post-certify non-medically necessary equipment or are compromised by a patient who pushes hard to receive a certain device. In adopting the policy, the House warned physicians to authorize medical equipment with care to avoid getting caught in the government's anti-fraud efforts.

Physicians with questions about DME can call the ISMS Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. Physicians who have identified questionable DME practices can report them directly to Blue Cross and Blue Shield of Illinois, the state's Medicare Part B carrier, at (618) 997-3190. ■

*Whether a physician knowingly approves a fraudulent claim or does so by mistake is unimportant to the government.*

## ADA requires changes in physician-employee relations

(Continued from page 15)

Equal Employment Opportunity Commission, an individual who has a relationship with an HIV-positive individual may not be denied employment or benefits on the basis of that association."

**TITLE I ALSO REQUIRES** measures to provide "reasonable accommodation" to the known physical or mental limitations of the employee, said Tilson. Such measures may include making employee facilities accessible; restructuring the job or reassigning a disabled employee to another position; acquiring or modifying equipment or devices used by the employee; developing training materials and formulating policies; and providing qualified readers or interpreters.

"Accommodation is not required, however, when it would result in 'undue hardship,' that is, it would entail 'significant difficulty or expense,' in relation to the employer's resources," said Tilson. Criteria for determining "undue hardship" in complying with employment provisions of the Act are similar to criteria for determining what is "readily achievable" in Title III of the Act, which covers facilities and programs and services.

**IN ADDITION, TILSON SAID,** the ADA will affect physicians who provide medical examinations of applicants with disabilities for other employers. "Physicians should remember that when conducting medical exams for employers, they need to know the essential functions of the

jobs of the employees who are examined."

Tilson said the EEOC has a detailed description of the physician's role when performing medical examinations for other employers. Simply stated, however, physicians may consider only two things when conducting such exams. The first is whether the person is currently able to perform the specific job for which he or she is applying, with or without reasonable accommodation. The second is whether the applicant can perform the job without posing a direct threat to the health or safety of himself/herself or others.

Tilson added that the EEOC strongly encourages physicians to take plant tours and learn about the person's duties, before performing the medical examination. "But in the final analysis, it's for the employer to determine whether it would be practical to accommodate somebody with a disability," continued Tilson. ■

## Physician HELpline

A 24-hour physician HELpline is available to link impaired physicians and their families with helpful resources. Contact the ISMS Physician HELpline at (312) 580-2499.



### Counseling, family planning are key components of abortion plan

At Cook County Hospital, women seeking abortion services, which were scheduled to resume July 30, will undergo a four-step process.

The first visit will include comprehensive counseling, including birth control education, a discussion of alternatives to abortion, a medical examination and pregnancy test, and financial counseling.

The procedure will occur on the second visit, after which the women will be discharged with an appropriate method of birth control and an

appointment at a family planning clinic. There will be a three- to five-day period between the first and second visits.

The third visit will be a post-procedure medical examination, and the fourth visit will involve in-depth counseling at a family planning clinic.

The program will be available only to Cook County residents, and no more than one abortion per person will be performed in a calendar year. Also, all women undergoing abortions will be expected to pay a fee that will be determined by the woman's ability to pay. ■

## Abortion gag rule on hold

**APPEAL:** The administration's so-called abortion counseling gag rule is on hold pending appeal of a federal judge's ruling that the regulations are illegal. By Kevin O'Brien

[ WASHINGTON, D.C. ] Confusion over what physicians can and cannot say when counseling pregnant women in federally funded clinics continues, as the issue wends its way through the courts.

Currently, there are no restrictions on physicians or any other members of the health care team, but that could change pending an appeal of the most recent

ruling in the 4-year-old dispute.

The Reagan administration on Feb. 2, 1988, issued the Title X family abortion regulation, which forbade family planning services funded by the U.S. government from discussing abortion.

Challenges that the so-called gag rule was unconstitutional because it prevented low-income women from receiving information regarding the right to a legal procedure failed when the U.S. Supreme Court upheld the regulation on May 23, 1991. The American Medical Association objected to the decision on the grounds that it unduly interfered in the physician-patient relationship.

Congress passed a bill last year overturning the ban, but President Bush vetoed it. To ward off a veto override, the president issued an order stating that "nothing in these regulations is to prevent a woman from receiving complete medical information about her condition from a physician."

On March 20, the U.S. Department of Health and Human Services issued guidelines that permit physicians to refer patients to facilities that offer a broad range of prenatal care and social services, including abortion. But they also say that such referrals must be based on medical considerations and that they preclude referral to facilities whose sole activity is providing abortions.

The AMA said Bush's action did not go far enough for physicians and agreed with other opponents who said it was virtually meaningless because most counseling in Title X programs is performed by nurses and counselors, not physicians.

Subsequent litigation resulted in a May 28 ruling by U.S. District Judge Charles Richey that the regulations are illegal because they were never released for public comment. The government has since filed a notice to appeal Richey's ruling. ■



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### Cook County scheduled to resume abortions

(Continued from page 1)

terfuge to establish a precedent by which they might somewhere down the line thwart what we're doing," Phelan said in a press conference. Phelan drew the distinction between a board of trustees of a private hospital and Cook County Hospital, which he said is governed by the board of commissioners and its Health and Hospitals Committee.

Phelan said the Joint Commission on Accreditation of Healthcare Organizations recognizes the Health and Hospitals Committee to be the governing entity for Cook County Hospital.

Although Phelan said he expects other attempts to stop implementation of his executive order, he added that "County Hospital will be ready to provide poor women the right to choose on July 30" and that abortions "may well begin" that day. ■





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PAGE 12

# Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • AUGUST 14 1992

## COUNSELING PATIENTS ON ADVANCE DIRECTIVES

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## HCFA announces new Medicare limiting charge compliance procedures

**MEDICARE:** Nonparticipating physicians are to be notified of overcharges every two weeks. By Kevin O'Brien

[ CHICAGO ] Nonparticipating physicians whose charges for treating Medicare patients exceed established limiting charges should receive the first of semimonthly reports detailing the possible overcharges in early August. New U.S. Health Care Financing Administration rules mandate that physicians refund to patients any billed amount found in excess of the limiting charge.

Blue Cross and Blue Shield of Illinois, Medicare administrators in Illinois, sent letters July 1 to nonparticipating physicians informing them of the new system. Illinois is among 10 states implementing the pilot program, which will be instituted nationwide later this year.

Congress established the limiting charges in the Omnibus Reconciliation Act of 1989. In 1992, the limiting charge on nonparticipating physicians is

generally 120 percent of the Medicare Non-Participating Physician Fee Schedule Allowance, the letter said.

According to Blue Cross, physicians whose claims exceed the limiting charge will receive a report, called the Limiting Charge Exception Reports (LCER), every two weeks. "At approximately the same time" the physician receives the LCER, patients will receive similar notification on Explanations of Medicare Part B Benefits notices. A Blue Cross spokesman said the first LCERs were scheduled to go out in early August, with patient notifications scheduled to start in late August.

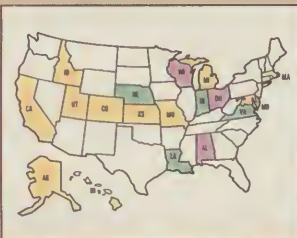
If a physician receives one or more LCERs, Blue Cross said it will "periodically monitor [the physician's] billing practices and, when necessary, verify that

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withstand the  
test of time

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### ISMS ELECTION WATCH

## PHYSICIANS: IF YOU HAVEN'T YET REGISTERED TO VOTE, DO IT NOW

It is about 2-1/2 months until election day, and the balloting this Nov. 3 could well mean the difference between advancing organized medicine's interests in Springfield and Washington, standing still or losing ground.

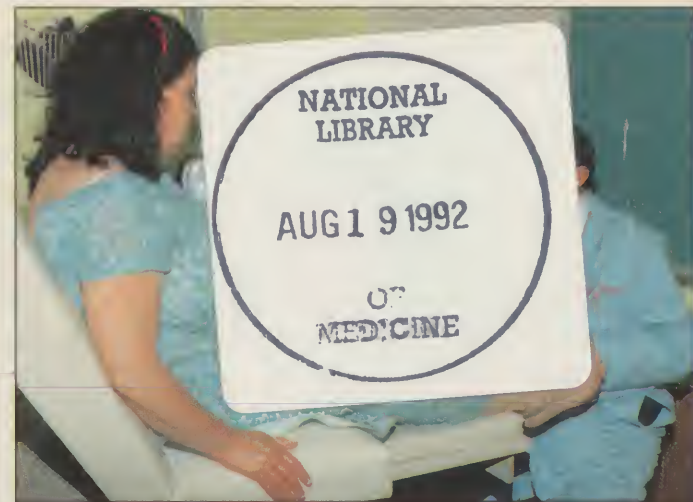
In addition to a hotly contested race for the U.S. Senate, all 177 seats in the Illinois General Assembly and 20 seats in the U.S. House of Representatives will be decided at the polls. (See story, page 5.) And this year redistricting offers physicians, their families and friends, and their patients a once-in-a-decade opportunity to help influence the health care legislative agenda for the next decade.

"But it won't mean a thing unless all those

folks vote," said George T. Wilkins Jr., M.D., chairman of the Illinois State Medical Society Political Action Committee. "And to vote, you have to register. So if you're not yet a registered voter, now is the time to take care of it."

The once-every-10-years' redrawing of congressional and legislative boundaries triggers several factors that have the potential to alter the legislature's composition for the next decade. In some redrawn districts, incumbents have decided to retire instead of running in unfamiliar territory. In others, redistricting pits incumbents from the same

(Continued on page 21)



BOB MACDONALD

**ISMS PRESIDENT ARVIND K. GOYAL, M.D.**, examines Rosalinda Lopez of Joliet at the Will-Grundy Medical Clinic as Mayra Lopez looks on. Dr. Goyal volunteered his time at the clinic July 22 as part of his president's tour.

## Government indictments announced in Medicaid beneficiary fraud investigation

**FRAUD:** Federal government investigations have turned up instances of Medicaid fraud in Illinois. By Tamara Strom

[ CHICAGO ] Included in 10 indictments handed down by the federal government July 28 for the theft of nearly \$500,000 in Social Security and welfare benefits are several instances of Medicaid fraud. The indictments, announced by U.S. Attorney Fred Foreman and Regional Inspector General Michael T. Dyer, are part of the government's ongoing crack-down on health care fraud. The Illinois Department of Public Aid helped in the investigation.

"There were no health care providers involved in this; that is, there was no doctor fraud," Dyer said. "There were some public aid recipients who weren't entitled to be in public aid who were also receiving Medicaid."

(Continued on page 22)



PAUL MCGRATH

**U.S. Attorney Fred Foreman (left) and Regional Inspector General Michael T. Dyer July 28 announced 10 indictments as part of an ongoing investigation of health care fraud. No physicians were indicted.**

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# Aurora to receive new hospital, surgical center

**HOSPITALS:** The Illinois Health Facilities Planning Board approved building applications for two new facilities in the western suburb. By Tamara Strom

[ AURORA ] After nearly two years of controversy over the location of a replacement hospital for its aging current structure, Aurora's Copley Memorial Hospital finally received a certificate of need to build a new hospital. The CON application for a replacement hospital in a burgeoning area of Aurora was unanimously approved by the Illinois Health Facilities Planning Board July 9.

Set to break ground in the fall, Copley officials are "extremely pleased" with the planning board's decision. "We were confident that our application would be approved because our plans conform to state guidelines in nearly every category," said Copley President and Chief Executive Officer Chet D. McKee.

The plan approved by the planning board this month was Copley's second submitted to the state. Last summer the board rejected the hospital's proposed move across state planning lines into DuPage County, saying adding another

hospital in that area would create a glut of services. That move also was bitterly contested by Edward Hospital and Central DuPage Hospital, which both claimed Copley was invading their turf in DuPage County. At stake were potential new patients from the rapidly growing suburban Fox Valley Villages area. Copley already has an urgent care center and physician office building in DuPage County.

But Copley now will construct its new 144-bed hospital three miles east of its urgent care center in its present planning area in Kane County. The new location will provide easy access for residents in East Aurora, neighboring Kendall County, and Oswego and Montgomery, said Copley spokesman Carolyn Wille. "[The new hospital site] is just a stone's throw away from our other property with the medical office building and urgent care center. Three miles is no big deal for physicians who have their offices there."

The new hospital also will make it easier for physicians to deliver care to their patients, McKee said, by establishing "centers of excellence" in areas such as cardiology, oncology, women's services, ambulatory surgical services and physical rehabilitation services. "These centers will be highly accessible to our patients, visitors and physicians, featuring 'one-stop' patient care and service," he said.

**AURORA'S DREYER MEDICAL CLINIC** also received the go-ahead from the planning board at the July 9 meeting to build an ambulatory surgical center. A joint venture with Mercy Center for Health Services, the surgical center will comprise four operating rooms and one special procedures room, mainly for physicians to perform endoscopies, said Dreyer President John Potter. Among the same-day surgeries to be offered are arthroscopy; cataract removal; ear, nose and throat procedures; dilation and

curettage; and oral surgery.

The surgical center will enable the surgeons affiliated with Dreyer to perform the "bread and butter outpatient surgeries" in the same building where many of these physicians will have their offices, Potter said. The facility is scheduled for completion in summer of 1993.

"There is no freestanding ambulatory surgical center in Aurora now, so this will be the first one in the area," Potter noted. "It will be geared toward same-day surgery with a family atmosphere. It's designed specifically for the outpatient."

Potter credits the planning board approval, in part, to Dreyer's submission of a fee schedule "that is very competitive and guaranteed to be frozen through 1993 and 1994."

In addition, he said, the demand for outpatient treatment centers is growing nationwide. The insurance industry, in particular, is pushing for such "lower cost environments" for health care provision to control rising costs, Potter added. "The Dreyer Clinic HMO also is seeking lower cost alternatives for our HMO patients," he said, explaining that the surgical center will fill some of that need. The HMO has 33,000 enrollees. ■

## Congress adopts student loan deferment curbs

[ WASHINGTON, D.C. ] Although lobbying from the medical community helped ease the bite, Congress this month adopted a House-Senate conference committee report reauthorizing the Higher Education Act, which limits student loan deferments for medical residents. Physicians contended that the government should continue covering the interest on medical school loans until residents complete their training. But faced with an ever-increasing federal deficit, Congressional lawmakers sought to save money by curbing lengthy deferments.

The legislation adopted allows residents facing economic hardship to defer loan payments for three years without incurring additional interest charges. The definition of economic hardship is yet to be determined, American Medical Association lobbyists said, but a provision in the law mandates that the residents' debt-to-income ratio be considered when determining hardship. The conference committee report also includes language grandfathering two-year loan deferments for students still in school and those who will have taken out loans before July 1, 1993, the AMA said.

Congress also reauthorized residents to put their loans in forbearance during their training. In addition, lawmakers guaranteed that students attending foreign medical schools remain eligible for student loans. ■

## AIDS commission rejects mandatory testing

[ WASHINGTON, D.C. ] In its report "Preventing HIV transmission in Health Care Settings," President Bush's National Commission on AIDS announced July 30 that mandatory AIDS testing for health care workers "is both misguided and unworkable in practice." The bipartisan panel, composed of

experts on the disease, found testing for exposure to HIV would be unnecessary and "counterproductive" in reducing AIDS risk.

The commission's recommendation parallels recently finalized guidelines on AIDS prevention in the health care setting issued by the U.S. Centers for Disease Control. Both the CDC and the Commission recommend the use of universal precautions to reduce the likelihood of blood and secretion exchange between health care worker and patient.

The panel also agreed with existing scientific evidence that risk of HIV transmission from provider to patient is extremely small. "For provider-to-patient HIV transmission to occur, the infected health care worker would have to sustain an injury and bleed into the patient's wound, or after sustaining an injury during an invasive procedure, have the sharp object causing the injury then recontact the patient's open wound," the report said. Invasive procedures pose a much greater risk to the provider, it said, stressing that breaches in infection control procedures are especially dangerous to health care workers.

Recent look-back studies conducted by

federal health officials of more than 15,000 patients treated by HIV-infected providers found no incidence of health care worker-to-patient transmission.

Public concern over contracting HIV from health care workers was sparked when five patients of a Florida dentist who died of AIDS tested positive for HIV. One patient, Kimberly Bergalis, died in December 1991. In Illinois, the death of a Nokomis dentist with AIDS led to the passing of S.B. 999, the HIV/AIDS notification law. Gov. Jim Edgar's Task Force on AIDS in Health Care recently developed guidelines for implementing the law as well as the CDC guidelines. The task force opposed mandatory AIDS testing for health care workers.

States are required by federal law to implement guidelines for preventing HIV transmission in health care settings by October. CDC guidelines denounce the restriction of practice of HIV-infected individuals but state that health care workers prone to exposure should know their serostatus. The commission discouraged requiring health care workers to disclose their serostatus to patients, stating that such practice "inflates the

risk of HIV transmission out of proportion to other risks and is inconsistent with the principles and practice of informed consent." ■

## AIDS Foundation of Chicago awards grants of \$300,000

[ CHICAGO ] Several AIDS service organizations in the Chicago area will share \$300,000 in grants from the AIDS Foundation of Chicago. The awards, ranging from \$2,500 to \$30,000, will benefit 25 organizations that support AIDS housing, education and prevention, volunteer resources, direct client assistance and advocacy.

This year's grants, the largest since the awards began in 1988, bring the foundation's total contributions to AIDS organizations to more than \$1 million.

"The need for private resources to fight AIDS is acute," said AIDS Foundation Executive Director Karen Fishman. "The AIDS Foundation of Chicago is delighted to be able to recognize and support the efforts of organizations serving people with HIV infection throughout the metropolitan area."

The Pilsen-Little Village Community Mental Health Center, Catholic Charities, Chicago Recovery Alliance, Cook County Hospital AIDS Prevention Services and AIDS Legal Council of Chicago were among this year's grant recipients. ■

## PHYSICIAN FACTS

### Births to teens in Illinois



Source: Illinois Department of Public Health

Area	1989	1990	% change
Illinois total	24,923	25,545	2.5
Chicago	11,416	11,528	1.0
Suburban Cook Co.	2,530	2,695	6.5
DuPage Co.	445	483	8.5
Kane Co.	680	756	11.1
Lake Co.	757	860	13.6
McHenry Co.	159	175	10.0
Will Co.	611	626	2.5

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## Humana Inc. explores dividing company, faces suit

[ CHICAGO ] The Louisville, Ky.-based Humana Inc., which operates hospitals and managed care plans throughout Illinois and the United States, announced July 9 plans to explore dividing into two separate publicly held corporations. One company – which officials anticipate will be headed by current Chairman of the Board and Chief Executive Officer David A. Jones – would operate Humana hospitals, including Chicago's Humana Hospital-Michael Reese. The other company would administer Humana Health Care Plans under the direction of Carl F. Pollard, the current Humana president and chief operating officer. The division would not take place until early 1993.

A day after the company announced its proposed division, a class action lawsuit was filed in Cook County Circuit Court alleging Humana's involvement in a conflict of interest. Spokesman Debbie Landers said the suit claims Humana failed to inform its customers that it acted as both health care provider and insurer for its HMOs. The allegations suggest the company violated state law and hospital accreditation standards. ■

## Chicago Medical School's physician assistant department opens

[ CHICAGO ] University of Health Sciences/The Chicago Medical School has opened its new physician assistant department. The department, the first of its kind in Illinois offering a bachelor's degree, will train students in all areas of family medicine, obstetrics-gynecology, pediatrics, emergency medicine and psychiatry, said Michael P. Pagano, Ph.D., chairman of the department. Eight students are enrolled in the program, and Pagano estimates future enrollment should reach 30 students per year.

The program begins with one year of course work taught by the medical school faculty. During the second, clinical year of the program, students are required to complete 10 four- to six-week clerkships with primary care physicians throughout the state. According to Pagano, the clerkships will be served in remote or inner-city areas where physicians are scarce.

Although the clerkships are to begin in June 1993, Pagano is trying to locate physicians who are interested in working with physician assistants. For more information about student PAs, contact Pagano at (708) 578-3312. ■

## MCHC seeks new referendum language

[ CHICAGO ] The Metropolitan Chicago Healthcare Council has asked the Cook County Board to reword and broaden the question in a referendum on national health care reform. The board June 15 OK'd the referendum for inclusion on the November ballot. The MCHC consists of 100 hospitals and health care organizations in the metropolitan area, of which 60 are

located in Cook County.

William R. Lewis, MCHC senior vice president, told the board at the conclusion of its July 7 meeting that while the council supports the concept of a referendum on the county ballot, it is concerned about the wording of the initiative.

"Rather than a call to completely overhaul our current health care system, the council suggests that [the county] board amend the referendum to present a more broad-based call to action on national health reform which builds on the benefits of our current system," said Lewis.

The referendum language adopted by

the county board states: *Should the state of Illinois urge the Congress and the President of the United States to enact a publicly funded national health insurance program that provides comprehensive health care for all citizens while giving everyone the right to choose their own hospital, doctor or other health care professional?*

Lewis noted that the county board's referendum excludes mention of private health care providers, who he said render a "very high quality of health care to over 80 percent of the nation's population."

Similar concerns were expressed by

Alan M. Roman, M.D., president of the Chicago Medical Society. He said CMS "is opposed to the referendum in its present form because it is too limited in scope, and there is not enough information provided for the voters to make an educated determination."

Lewis proposed alternate language that states: *Should the state of Illinois urge the Congress and the President of the United States to reform our nation's health care system to enact a health care program that relies on both the public and private initiative and provides access to comprehensive health care for all citizens regardless of their ability to pay?* ■

# Blue Cross Blue Shield



## REPORT FOR Illinois Physicians

### A Reminder for the MPP/PPO Physician

Blue Cross and Blue Shield of Illinois (BCBSI) would like to take this opportunity to reiterate the following important billing information to the more than 16,000 physicians participating in BCBSI's Mutual Participating Provider (MPP) and Participating Provider Option (PPO) programs.

#### MPP PARTICIPANT

The Mutual Participating Provider (MPP) program contract specifies that the MPP physician bill BCBSI only and not the BCBSI subscriber for services that are contractually eligible under the subscriber's usual and customary (U&C) contract. While the physician may bill the subscriber for contractually ineligible services and for any deductible or coinsurance amounts payable under the subscriber's contract, the MPP physician agrees to accept BCBSI's U&C allowance as full payment for contractually eligible services and agrees not to bill the BCBSI subscriber for covered services in excess of U & C allowances.

For example, if the U & C allowance for a billed, eligible procedure is \$500.00 and there is a 20% coinsurance amount to be paid by the subscriber, BCBSI will issue a \$400.00 payment to the physician and the subscriber will be responsible for the remaining \$100.00.

#### PPO PARTICIPANT

The PPO physician bills BCBSI only and not the BCBSI subscriber for services that are contractually eligible under the subscriber's PPO contract. While the physician may bill the subscriber for contractually ineligible services and for any deductible or coinsurance amounts payable under the subscriber's contract, the PPO physician agrees to accept the lesser of his/her charges or the maximum allowance according to BCBSI's Schedule of Maximum Allowances as full payment for each service covered under the subscriber's contract. In addition, the PPO physician agrees not to bill the BCBSI subscriber for covered services in excess of maximum allowances according to the Schedule of Maximum Allowances.

For example, if the lesser of the physician's charges and the maximum allowance according to the Schedule of Maximum Allowances for a billed, eligible procedure is \$500.00 and there is a 20% coinsurance amount to be paid by the subscriber, BCBSI will issue a \$400.00 payment to the physician and the subscriber will be responsible for the remaining \$100.00.

If you have questions about the MPP or PPO programs and how they can work for you or for information on electronic submission of your professional claims to BCBSI, please contact BCBSI's Provider Assistance Unit at (312) 938-7340.

#### Place of Service Codes

As a reminder and as published in the July 17, 1992 *Blue Cross Blue Shield Report for Illinois Physicians*, Blue Shield of Illinois is now accepting for the submission of your paper claims the new two-digit Place of Service (POS) codes required by Medicare B. Please continue to use the one-digit POS codes for the submission of your electronic claims until further notice from Blue Shield of Illinois.

(This report is published as a service to the physicians of Illinois.)

(8/14/92)



# Credentials, supervision all-important in midwifery

**MIDWIVES:** Most physicians and medical organizations agree: Lay midwives lack the education to practice safely.

By Anna Brown and Tamara Strom

[ CHICAGO ] Although only 10 states currently allow nursing by non-nurse or "lay" midwives, the debate over the practice has raged for years. Many medical organizations agree that physicians alone cannot handle the overload of women requiring prenatal care and that availability of care is woefully low in rural areas.

But experts also agree that the key issue is quality of care, and the credentialing of non-nurse-midwives could directly impact patient safety.

"With a certified nurse-midwife under the direct supervision of a physician, the patient can feel confident that the midwife is qualified within the scope of the law and has received formal, documented training," said Arvind K. Goyal, M.D., president of the Illinois State Medical Society. "Ultimately, only the physician with his medical education and training has acquired the knowledge and credentials necessary to provide the best possible care for a patient in the hospital setting. Nurse midwives, who work with physician supervision, serve as an acceptable choice for women seeking other health care options."

On Jan. 1, 1992, an amendment to the Illinois Medical Practice Act took effect that bans the treatment of "conditions and ailments" without a medical license. This change sprang from a 1988 lawsuit in which a lay midwife and her apprentice participated in a Taylorville home birth in which the infant died. The family did not press charges, but the state did, and the two were indicted for practicing medicine without a license. But because the Medical Practice Act at the time specified only the treatment of ailments, the law was deemed too vague. Charges were dropped, and the defendants challenged the law's constitutionality in federal court, where the judge ruled that states have the right to regu-



late midwifery.

Yet even though lay midwifery is illegal in Illinois, lay midwives continue to practice. The Illinois Alliance of Midwives, formed in 1983, believes that acceptance of lay midwifery would help its practitioners receive physician and hospital backup when birthing complications arise.

Valerie Morris, a lay midwife and past president of the Alliance, attends births throughout northern Illinois and delivers between 60 and 70 babies a year. Despite the amendment to the Act, she continues to do so. "A lot of people agree that it is not necessary to be a nurse to be a good midwife," she told *Illinois Medicine*. "Midwifery in this country is based on the nurse-midwife model. To a degree, that's fine. A lot of nursing skills are required, but [lay midwives] set certain standards for practice and training. That's the basis behind our push for licensure. You'll find most midwives work with backup physicians. We agree that a good backup is really necessary."

Unlike certified nurse-midwives, lay midwives are not protected by the supervising physician's malpractice insurance. Some physicians believe this puts mothers and children at even greater risk.

"Certified nurse-midwives have the training required to recognize a problem when it occurs, respond and refer to the appropriate individual," said M. LeRoy Sprang, M.D., ISMS Third District trustee and an Evanston Ob/Gyn. "They have more experience and expertise. Someone with limited training may not even recognize that they're in trouble, and that spells disaster for mother and child."

"We work by and large with a very healthy population, so we're not as likely to come into a situation where a suit may come about," Morris countered.

"Overall, home birth is really only appropriate for low-risk women. It's mythology that midwives can't have safe home births without hospital backup. But home isn't a good place to be for women with potential problems."

Both the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives

professional responsibility for the progress and outcome of care" and that such responsibility "cannot be delegated or assumed by a nonphysician." The college holds that sharing information by chart review is critical in providing quality care and that communication between the Ob/Gyn and the nurse-midwife must be made a part of written protocol.

ACNM holds its members to a strict code of ethics, which includes interacting "respectfully with the people with whom they work and practice." In its philosophy, the college states its intention to "encourage continuity of care; emphasize safe, competent clinical management; advocate nonintervention in normal processes; and promote health education for women throughout the childbearing cycle." ACNM stresses, however, that this can most effectively be accomplished "in collaboration with other members of an interdependent health care team."

"We don't oppose experienced, educated midwives," said Dr. Sprang. "We do oppose those who lack the proper credentials and proof of training. We do so for the patient's well-being, no other reason. This is not a turf issue; it's a quality of care issue."

ISMS policy is to support the use of properly and adequately educated and trained nurse-midwives, provided that one-on-one supervision by a physician is guaranteed and that the same physician retains responsibility for the medical care provided by the nurse-midwife. ■

*"We don't oppose experienced, educated midwives. We do oppose those who lack the proper credentials and proof of training."*

M. LEROY SPRANG, M.D.

impose strict guidelines governing who is certified to participate in labor and delivery, and how such care is provided. Although ACOG supports "actions that improve the experience of the family," it insists that this experience should occur only in hospitals that conform to the standards outlined by the American Academy of Pediatrics and ACOG.

ACOG also states that "optimum quality of care is assured only when the physician maintains a high degree of

## Encephalitis outbreak possible this year

**ENCEPHALITIS:** The presence of an encephalitis-causing virus in birds in southern Illinois holds the potential for a summer outbreak of the disease. By Tamara Strom

[ SPRINGFIELD ] Some birds in southern Illinois counties are infected with the St. Louis encephalitis virus this summer – a warning that human encephalitis cases could be on the way, according to the Illinois Department of Public Health. Although there have been no reports of humans contracting this particular virus since 1988, the increased number of bird carriers this year provides the opportunity for an outbreak, said IDPH Director John R. Lumpkin, M.D.

"At this point there is no need for undue alarm, but it is time for increased awareness, surveillance and control activities," Dr. Lumpkin said.

Seven birds in 12 southern Illinois counties tested positive for the St. Louis strain of encephalitis – two in Cumberland County, two in Richland County, one in Clay County, one in Fayette County and one in Madison County, Dr. Lumpkin said. Each year, IDPH takes blood samples from birds around the state to test for encephalitis. Only one bird tested positive for the virus between 1988 and 1991, he said.

Because of this year's higher incidence of the virus in the bird population,

physicians should be on the lookout for patients exhibiting symptoms that resemble arbovirus infections – those diseases transmitted by insects such as mosquitoes. Dr. Lumpkin asked that physicians send blood samples from these patients to IDPH to determine if the St. Louis virus is present. Because the virus has been identified mainly downstate, Dr. Lumpkin said physicians in Vermillion, Champaign, Piatt, Macon, Sangamon, Morgan and Pike counties and all Illinois counties south of these should be aware of the potential for encephalitis this summer.

The disease is transmitted to people by mosquitoes that contract the virus by biting infected birds. Most people who are bitten by mosquitoes carrying the virus do not contract the disease; for those who do, symptoms typically appear five to 15 days following the insect bite, IDPH said. Symptoms range from a slight fever or headache to a severe headache, high fever, muscle aches, stiff neck and disorientation. Although most patients recover fully, severe cases could result in neurological damage or death. ■

## Lyme disease cases down in Illinois

**LYME DISEASE:** Only three cases of Lyme disease have been reported in Illinois this year. By Tamara Strom

[ SPRINGFIELD ] Although the U.S. Centers for Disease Control classifies Lyme disease as the nation's second-fastest-growing infectious disease behind AIDS, Illinois has seen a downturn in cases this year, according to the Illinois Department of Public Health. Through June 30, only three cases had been reported to IDPH, down from 33 cases during the same time period last year, said IDPH spokesman Tom Schafer.

"Statewide the numbers are low this year; it's pretty quiet," Schafer said.

IDPH is uncertain what caused the decrease, Schafer said, but it could be attributed to lag time in diagnosing and reporting Lyme disease cases by physicians. "Or it could be an indication that the ticks' activity level is low this year," he added. Since 1982, in Illinois 190 people have contracted Lyme disease,

according to CDC statistics.

Despite the seemingly low incidence of Lyme disease this year, physicians should continue to consider the disease a potential threat to their patients. "Although Lyme disease may be present all year round, it peaks in the summer and early fall, when the ticks are most active and more people are outdoors," said Renee Reich, M.D., a pathologist at Elmhurst Memorial Hospital. "Lyme disease is important to us in Illinois because a lot of people travel to Wisconsin frequently."

The deer ticks that carry Lyme disease are usually found in the northeastern and western United States, as well as the upper Midwest, including Wisconsin and Minnesota, Dr. Reich said. Deer ticks also can be found in wooded areas of Illinois. ■



# Local races count for physicians

**ELECTION:** Redistricting set the stage for congressional and General Assembly contests that will greatly impact issues important to physicians. By Kevin O'Brien

[ CHICAGO ] 'Tis that season again: specifically, the quadrennial political slugfest that grips the nation at all levels of government. So far, the summer is showcasing a presidential contest that is giving Democrats a long-unfamiliar sense of anticipation – and Republicans an equally unfamiliar case of anxiety.

But for Illinois physicians, it is the local races that really count, and redistricting is the main reason. Following the national census every 10 years, boundaries in all congressional and legislative districts in the country are redrawn. Thus, come November, Illinois voters will be electing legislators in all 118 Illinois House districts and 59 Senate districts. This contrasts with the normal biennial legislative elections, when all House seats and a third of the Senate seats turn over.

Although Illinois politicians agreed early on to a congressional map, they achieved no such consensus for the General Assembly districts. This year's election is notable because the Republicans won the drawing giving them a majority on the redistricting commission. Thus, the legislative map that finally gained court approval makes it possible for Republicans to regain control of the Illinois Senate. The House GOPs are also hopeful of gains.

**A FEW RACES OF PARTICULAR** interest deserve mention. In the new House District 73, for example, the only physician in the General Assembly, Rep. David Deets, M.D., is running for election in his own right. Appointed in March to fill the unexpired term of Rep. Myron Olson, who died in January, Dr. Deets could play a major role in the debate over additional malpractice reforms – including caps on noneconomic damages. Dr.



Rep. David Deets, M.D. (left), is running for the Illinois House of Representatives this November; Herbert Sohn, M.D. (right), seeks Rep. Sidney R. Yates' seat in the 9th Congressional District.



Deets, a general surgeon from Dixon, faces Democrat Pennie L. Von Bergen Wessels.

**NOWHERE IN THE STATE** will the differences between tort reform proponents and opponents be more apparent than in the 102nd House District in central Illinois. Republican incumbent Rep. Duane Noland, who supports caps on noneconomic damages in malpractice suits and who opposes universal health care legislation, is facing Democrat Doug Wolfe, a former television reporter from Decatur. Wolfe became a consultant for the Illinois Trial Lawyers Association after resigning from his broadcasting job.

Other House races that *Illinois Medicine* will be following include several that pit two incumbents against each other in newly drawn districts. Covering parts of Lake County and Cook County is the new 59th House District, where

faces Democrat Rep. Helen F. Satterthwaite.

**THE ILLINOIS SENATE** will also see some hotly contested races as Republicans campaign to take over the upper chamber. In Chicago's northern suburbs, Democrat Rep. Grace Mary Stern is challenging incumbent Sen. Roger A. Keats in the new 29th Senate District. Keats has long supported organized medicine's issues, but House veteran Stern, who sponsored the repeal of the premarital AIDS test, is a proven vote-getter who could give Keats a good race.

Also seeking a promotion from the House to the Senate is Republican Rep. Karen Hasara, a strong supporter of organized medicine's view. She faces Democrat Douglas Kane, a former state representative, in the 50th Senate District, which includes Springfield. A similar contest in the 18th Senate District pits a Democrat House incumbent, Rep.

ments, services that included restaurant and water and sewer inspections. Madison County is the largest county without a local health department, Schafer said. IDPH has been urging these counties to establish health departments, but most had relied on the state to provide the services.

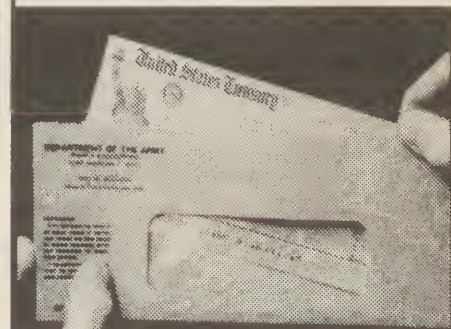
"We won't be able to offer these services anymore," Schafer said. "If we get a complaint about a restaurant, for example, we'll [investigate], but we won't do routine inspections anymore. It's unfair to those counties that provide these services out of [local] tax dollars to see neighboring counties getting a free ride [from the state]."

Despite the program cutbacks, IDPH considers itself fortunate the layoffs did not go deeper, Schafer said. "The cuts are about half what we had anticipated, even though we continue to get down to bare bones," Schafer said, noting that IDPH limited the staff cuts by shifting some positions into federal line items, approving early employee retirements and eliminating all paid overtime. "We don't have a lot of room left. Any additional cuts will mean more program cuts."

John J. McNamara, in a very tight race against a local attorney, Republican Patrick O'Malley.

In addition to the much-touted U.S. Senate race between surprise Democratic primary victor Carol Moseley Braun and Republican attorney and former White House aide to President Reagan Rich Williamson, several U.S. House races merit physician interest. One of those features Illinois' other physician candidate, Herbert Sohn, M.D., a Chicago urologist. For the fifth time, Dr. Sohn is running for Congress in the 9th Congressional District, taking on Democratic Rep. Sidney R. Yates, who has held office since 1948.

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## IDPH layoffs result in program losses

**LAYOFFS:** Budget cuts have forced the Illinois Department of Public Health to lay off 74 staffers, resulting in program cuts. By Tamara Strom

[ SPRINGFIELD ] The Illinois Department of Public Health July 24 issued pink slips to 74 employees, a direct result of the department's \$6 million funding cut in the state's fiscal 1993 budget. Effective Sept. 1, the layoffs will force the agency to curtail or eliminate some public health programs, IDPH said.

"In an effort to live within the boundaries established with this budget, we have prioritized programs and activities throughout the department to protect Public Health's core functions," said IDPH Director John R. Lumpkin, M.D. "This goes well beyond the orderly downsizing of this department the governor proposed in his April budget. However, we are committed to meeting our fundamental obligations to the people of Illinois."

Dr. Lumpkin said IDPH will maintain its current efforts in public health and safety programs on such subjects as

infectious diseases, infant mortality, AIDS, and maternal and child health.

Although IDPH cannot reduce its responsibilities to regulate hospitals, nursing homes and other health care facilities, the department will scale back its investigations of nonemergency complaints, said spokesman Tom Schafer. Prior to the budget cuts, IDPH staff followed up every public complaint it received about health facilities, a total of 5,000 complaints a year. Now, only those "requiring urgent attention" will be immediately investigated on site, Schafer said. The remainder will be handled during routine inspections of the facilities.

IDPH also will eliminate an entire division that acted as a liaison for local health departments, providing resources and expertise only as needed. In addition, the department will eliminate services to the 14 Illinois counties that do not have their own local health depart-



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## EDITORIAL

# Don't forget advance directives

List makers among you will recognize the phenomenon of crossing off tasks on the "to do" list and forgetting about them. It gives you a feeling of accomplishment. Perhaps that's how we are treating the issue of patient advance directives.

Largely through the initiative of the Illinois State Medical Society, Illinois has a series of legal alternatives for patients to determine what happens to them in the case of terminal illness or injury. There's the living will (declares your intent in the case of incurable and irreversible conditions) and the durable power of attorney (declares who can make what decisions in such events). In 1991, Illinois added a third option to ease end-of-life decisions. This is the Health Care Surrogate Act, which allows a surrogate to make life-sustaining treatment decisions if a patient is in a terminal, incurable or irreversible condition but lacks the ability to make a decision. Safeguards exist within the law to protect the patient, and the surrogate option can be exercised under only specific conditions and if the patient has no advance directive.

ISMS was instrumental in passing all three laws. ISMS was the driving force behind the Surrogate Act. Beyond enacting legislation, ISMS has developed, published and distributed "A Personal Decision," a document that explains the options, as well as provides the tools to execute, the living will, durable power of attorney and organ donation. Thou-

sands have been distributed to physicians, health care institutions and patients.

When the Surrogate Act passed, much attention was paid to its merits. The medical, hospital and legal communities were praised for supporting such a pro-patient, model piece of legislation.

It's been a year since the Surrogate Act was signed by Gov. Jim Edgar. We think it's time to re-raise our consciousness about advance directive options. We all know how easy it is to put off doing tasks. We all know that most of our patients don't anticipate for themselves what we, as physicians, see all too often: a patient in a permanent, irreversible, incurable state.

Physicians could and should more often talk to patients about advance directives. In addition to a patient brochure, ISMS has materials to help physicians understand advance directives and talk to their patients. Patients often don't know their options, and if they do, research has shown they're waiting for you to bring it up.

Add advance directives to your "to do" list for every day. Talk to patients about advance directives and options. Order materials from ISMS to help you get the conversation started. The legal options our patients have today will do them little good if they don't exercise them. Let's help them keep these treatment decisions where they belong - with patients, their families and their physicians. ■

## PRESIDENT'S LETTER

# Some columns are written with tact; others tell the truth

By Arvind K. Goyal, M.D.



*"Some of the biggest bills our sickest patients see come from our hospitals."*

A hillbilly made his first visit to a hospital where his teenage son was about to undergo an operation. He was surprised when an anesthesiologist came along. "What would you do?" the anesthesiologist was asked. "After I give him the anesthetic, he won't know a thing, and then we can go ahead and operate." "Save your time and my money, doc," the man explained. "He don't know anything now."

The anesthesia indeed couldn't be saved in this case. However, his suggestion reflected thinking.

Some of the biggest bills our sickest patients see come from our hospitals. Unfortunately, many of our patients assume that physicians are a part of the system. We somehow must benefit from hospital revenues, they think, probably because that is the norm in many business relationships outside of medicine.

The boards and management teams at most private nongovernmental hospitals consist of successful business people who work to promote an optimal patient care environment. In most hospitals the board members are brought in at the recommendation of chief executive officer (CEO) or administrator, not elected or selected by the communities - even those served by community hospitals. The board in turn is responsible for hiring, firing and paying a CEO they can trust to run the shop in accordance with set policies of the board. Most board members seem to know only what their CEOs tell them, maintaining a low profile at the hospital other than attending board meetings held once a month, on average. Organized medical staff leaders typically have a minority representation on a hospital board with terms limiting their time, experience and opportunity.

Many of our hospitals are "not for profit," which implies they do not pay taxes on their profits. Those profits instead are spent paying for an increasing administrative bureaucracy and sustaining an ever-expanding dynasty of buildings, equipment and other ventures: MRI scanners, cardiac surgery units, 24-hour emergency and walk-in facilities, outpatient surgicenters, home nursing and nursing home outfits, real estate and, lately, office buildings. Many of these entrepreneurial facilities are miles away from original hospital in structure and mission, and have nothing in common except the hospital's name and a common interest: the money! And now physicians' practices are being purchased and run by some hospitals on the cutting

edge, notwithstanding the fact that corporate practice of medicine is prohibited in Illinois. I do not know of any hospitals that have taken to selling cars or operating airlines yet! Competition, these hospitals say, makes them wander into previously unexplored territories.

Many hospitals in recent years have experienced shrinking bed numbers, increased regulatory controls and cost shifting imposed by governmental programs (Medicare and Medicaid) and managed care contracts. Eroding profits are detrimental even to some of the noblest in the industry. A hospital then gets involved in doing everything possible - that is, anything it can get away with - and at a cost as high as the market will bear. This is America, they say; making money is American.

Whereas a typical hotel room costs up to \$100 nightly for two people, a hospital bed and board in a room shared by two patients with nursing coverage around the clock goes at \$400 a night, much higher in an intensive care or coronary care unit. In addition, laboratory, pharmacy, EKG, radiology, physical therapy, respiratory and other services are billed on an itemized basis. An order for PRN oxygen or aspirin, I recently found out, generates a regular charge on the bill, needed or not. Stat orders for tests or medications and many weekend services cost extra. Those patients who are used to paying a few cents for a Tylenol tablet at a drug store get excited when they see a \$3 charge for the same on a hospital bill! The administrative numbers and salaries progressively look better, while the nurses and other hospital employees "just work here"! Their responsibilities keep increasing by leaps for relatively measly cost of living increases.

Then there are some stories of abuses and potential conflicts at some hospitals that may shake the public trust. Some changes need to occur. Some checks and balances need to be put in place quickly. Exclusive contracts granted to favored parties, selective "no bid" consultation contracts, sometimes for doing nothing, attempts at economic credentialing of medical staff members, specified minimum number of hospital admissions or procedures required for reappointment, and other such questionable practices do not measure up to hospitals' stated mission of service. There are more reasons than just costs to know the workings of our hospitals.

A man is known by the company he keeps. A physician is frequently known by the hospital medical staff he or she is on.





## GUEST EDITORIAL

## Is a Canada-like health care system right for us?

One of the hottest topics on this year's campaign agenda is health care reform. There are many proposals to deal with this problem. Among the proposals in Illinois is the Universal Health Care Act. This act would institute a Canadian-model health care delivery system in Illinois. The plan would provide a broad range of services to all people, with no "out of pocket" expense. It would provide coverage for more services than many current expensive private insurance plans offer. Currently, many people in the state aren't receiving health care services; therefore, a government-administered system where all services will be provided to all people without increasing cost simply doesn't make sense.

First, the care would be perceived as "free" because there would be no direct patient payment linked to the service. There are no restraints in the proposed system to deal with the inevitable overutilization that will occur. Secondly, there would be a huge increase in demand leading to long delays in the provision of services. This currently is the situation in Canada, where some patients must wait two months for an urgent Pap smear, six months for a hernia repair, two months for cataract surgery, six to 10 months for hip replacement and up to three months for coronary bypass surgery.

These services are not "free" as implied by the supporters of the plan. It is predicted that the state income tax would almost triple just to keep even with present costs. As well, there will be a nearly 11

percent payroll tax, forcing employers to increase product costs and/or decrease wages.

The United States and Canada are very different. Canada does not have the same inner city, drug addiction, violence, AIDS, poverty or teenage pregnancy problems. Canada does not suffer the high cost of litigation present in this country. These major differences are not addressed in the proposed system.

The proponents of the system also do not mention that the Canadian system has not been successful in containing health care costs. Greater numbers of Canadian citizens are buying private insurance each year to pay for services not covered under the government plan. Per capita health care costs are rising at a greater rate in Canada than in the United States.

I do agree that there is a problem with escalating health care costs, both in Illinois and across the nation. I also agree that there should be improved access for many of the citizens of this state. I am in favor of ensuring universal access to basic health care services for every citizen, regardless of ability to pay.

The proponents of this plan claim that this system would solve the health care cost crisis in our state. It is my opinion that this system of health care delivery will not work in our state. It will lead to increased costs and a dramatic decrease in the high level of health care now available to the citizens of Illinois.

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**William E. Kobler, M.D.**, a member of the Winnebago County Medical Society Board of Directors and District Twelve trustee for the Illinois State Medical Society, specializes in family practice.

## GUEST EDITORIAL

## A potential land mine in the PSDA field

BY LAUREL A. BURTON, TH.D.

SUZANNE YELLEN, PH.D.

ELLEN ELPERN, M.S., R.N.

ROGER BONE, M.D.

Just when we thought the major battles about patient rights with regard to decision-making for the incapacitated were over and it was safe to get on with other business, we had a terrible thought: What if the Health Care Surrogate Act sabotages the Patient Self Determination Act?

For several years, we have strongly advocated the idea of advance directives. The Patient Self Determination Act is, we believe, a dynamic step in the continuing shift from paternalism to mutuality in health care decision-making. For many of the same reasons, we are strong supporters of the Illinois Health Care Surrogate Act. We see it as an appropriate way to empower concerned and involved people to make decisions about health care for loved ones who left no advance directive. The disturbing thought that occurs to us is this: What if doctors and others place only minimal emphasis and energy on implementing the Patient Self Determination Act, believing that it will somehow be easier to raise the issue of whether or not to forgo life-sustaining treatment *after* a patient is unable to speak?

In recent years, physicians have demonstrated something less than a full commitment to initiating conversations with their patients about what type of medical interventions they would prefer as death becomes imminent.

Along with their patients, physicians may believe that such conversations and decisions are important, but research suggests that they rarely discuss the issues with their patients, nor do they follow through. This may be related to their view of medicine as extending life or defeating death, or it may simply be a matter of the personal discomfort caused by these discussions with patients. Whatever the reason, it can be problematic.

It is possible that advances in medical technology have inappropriately defined the world of the modern hospital and much of contemporary medicine. Prior to these technological miracles, physicians may have been more accustomed to the prospect of their patient's dying, viewing death as something that was beyond their control, particularly in cases of terminal illness. Just as technology has changed the dying process, so too it may have disrupted the doctor-patient relationship. Reliance on technology alone is not sufficient.

It is still the physician who directs the multiple aspects of medical care. Even with our understanding of patient rights and the importance of patient participation, it is the doctor who possesses the knowledge and much of the power to treat and cure. Fortunately, most physicians desire to use their pow-

er to care about their patients' well-being as well as treat and cure them. That is why many doctors support the Patient Self Determination Act and the Health Care Surrogate Act. However, personal support has not been translated into practice; there has been no increase in patient-doctor dialogue about end-of-life decisions. This means that physicians must now place even greater emphasis on conversations with, and empowering decisions for, their patients if they are to exercise appropriate care for their patients. It will not do to wait until the patient can no longer communicate, nor is it appropriate to assume that patients are too uncomfortable with the topic for their doctors to bring it up.

In a study we conducted recently with inpatients, outpatients and citizens who were not currently seeking medical treatment, only 32 percent had heard of durable power of attorney for health care. Yet, slightly more than 80 percent of our respondents said they would be either very comfortable or somewhat comfortable receiving information about advance directives. More than half of them wanted this information before any potential hospital admission. Further, most (95 percent) felt either somewhat or very comfortable talking about these issues with their physicians.

If patients are truly to be self-determining, they need information and opportunities to talk about their options with the physician who cares for them. The intent of the Patient Self Determination Act is to provide just such opportunities for patients so they can participate in decisions about their care. Physicians must help facilitate these discussions. They must not assume that if their patients don't bring up the topic, that the Health Care Surrogate Act is enough. It is not. The guidelines provided by the Health Care Surrogate Act may be helpful in decision-making when no other options are available. With the Patient Self Determination Act and advance directives, there are important options. Physicians must do everything in their power to create an environment where patient choice in these matters may be discussed, expressed and exercised. ■

*The co-authors are all affiliated with Rush-Presbyterian-St. Luke's Medical Center or Rush University. Dr. Burton is the Bishop Anderson Professor of Religion and Medicine. Dr. Yellen is a psychologist associated with the Rush Cancer Center. Ms. Elpern is a nurse practitioner in pulmonology. Dr. Bone, an ISMS member, is vice president for medical affairs and dean of Rush Medical College.*



# Cook County Hospital abortions on hold pending Aug. 12 hearing

**ABORTION:** A judge grants a temporary restraining order to halt start-up of abortions at Cook County Hospital one day before they were scheduled to begin. By Kevin O'Brien

[ CHICAGO ] A Cook County circuit court judge July 29 blocked the resumption of elective abortions at Cook County Hospital one day before the procedures were to begin. A full hearing on the matter was scheduled for Aug. 12.

Chancery Division Presiding Judge Richard L. Curry granted a temporary restraining order pending disposition of a suit brought by four county commis-

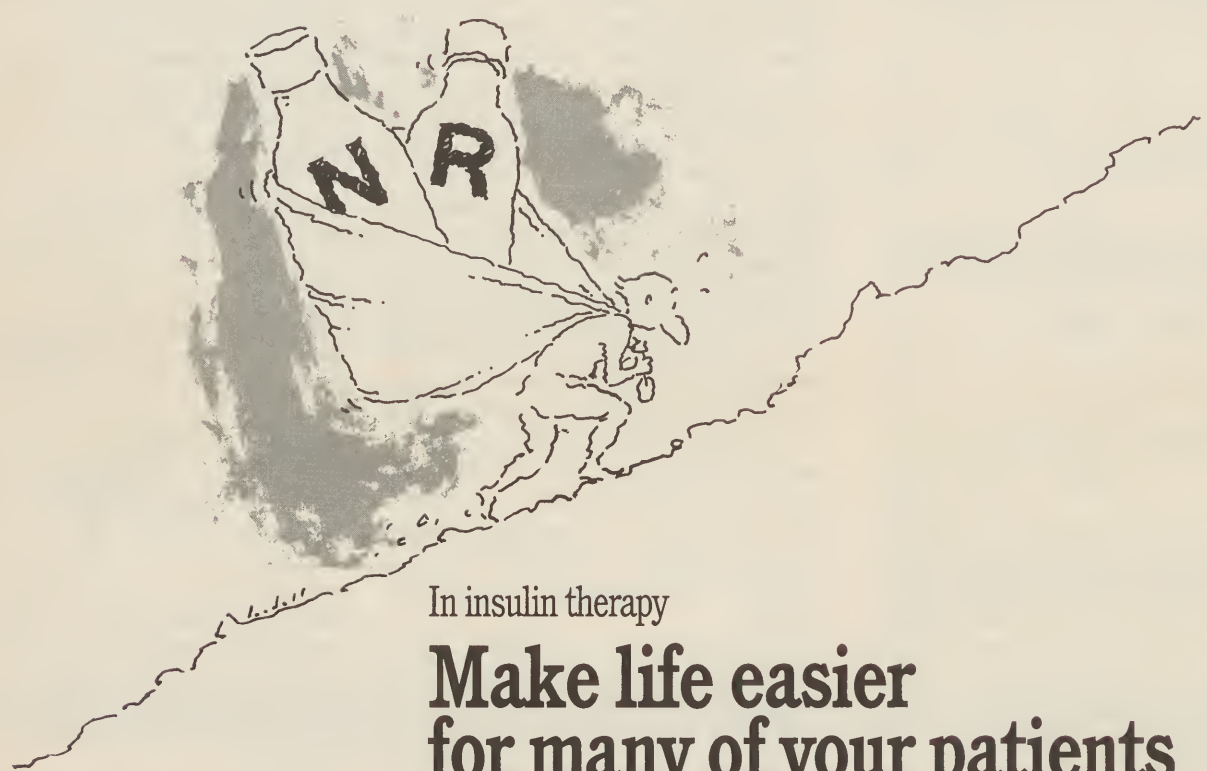
sioners. In their suit, Commissioners Carl R. Hansen (R-Mt. Prospect), Mary M. McDonald (R-Lincolnwood), Herbert T. Schumann Jr. (R-Palos Hills) and Richard A. Siebel (R-Northbrook) contend that County Board President Richard J. Phelan overstepped his authority when he issued a June 18 executive order reinstating the procedure at the public hospital.

Elective abortions at Cook County Hospital ceased in 1980 when then-President George Dunne issued a similar executive order. At Dunne's request, the County Board subsequently voted to "concur" in Dunne's action. Phelan has maintained that because the County Board did not pass an ordinance ratifying Dunne's order, their "concurrence" did not constitute official policy and is

not binding on his administration.

Outlining in some detail what they termed a "judicially actionable paper trail," James A. Davids and Joseph A. Morris, attorneys for the plaintiffs, told Curry that only the board has the authority to make policy for the hospital and that the board did precisely that in 1980.

Phelan said 10 women had been scheduled to undergo the procedure on July 30. As of July 31, at least 32 women scheduled to have abortions at Cook County Hospital had been referred to Planned Parenthood's Midwest Center. ■

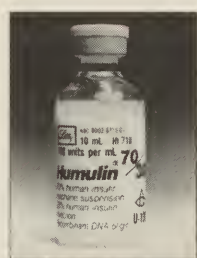


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# ISMIE Update

## MALPRACTICE ROUNDUP

PAGE 10

### Malpractice caps withstand the test of time

**TORT REFORM:** A minority of states have imposed caps on medical malpractice awards, and over time, these caps have proven effective. By Kathy Meyer

[ CHICAGO ] Since the medical malpractice crisis of the mid-1970s, virtually every state in the nation has passed some type of tort reform to enhance physicians' access to affordable coverage and patients' access to quality care. Just under a third of all states legislated caps of some kind on jury awards. Although these caps have met strong opposition from the plaintiffs' bar, for the most part they remain intact and effective.

To date, 15 states have some type of cap on malpractice awards. These vary widely in scope, from \$225,000 to \$500,000 on noneconomic damages and up to \$1.25 million on total damages.

In most states it has taken a crisis for lawmakers to enact malpractice caps. In California, legislators ignored warnings of the ensuing malpractice crisis for nearly a decade. In 1975, a 350-percent premium increase by the only two medical malpractice insurers remaining in the state forced many physicians to abandon their practices or to "go bare." Legislators quickly passed the Medical Injury Compensation Reform Act (MICRA), which set a \$250,000 cap on noneconomic damages, among other reforms.

That same year a less severe situation in Indiana brought together opposing sides — the medical establishment and the plaintiffs' bar — to craft a comprehensive tort reform package. The Indiana Compensation Act for Patients (INCAP) includes a cap on total damages.

Despite such "team efforts," organized medicine met strong resistance in every effort to legislate caps. "It was a give-and-take all the way," said Mason Howard, M.D., chairman and chief executive officer of the Colorado Medical Society. For the Colorado medical establishment to get what Dr. Howard calls a "leaky cap" passed, it had to concede any limits on attorney contingency fees.

Colorado's \$1 million cap on

total damages, including a \$250,000 cap on noneconomic awards, contains an escape clause. The court can award damages over that amount to compensate plaintiffs with permanent disabilities for health care costs and lost wages. The court has exercised that option only once, awarding a 63-year-old man \$1.6 million when a misdiagnosis of prostate cancer left him impotent from unnecessary surgery. The insurer, Copic Insurance Co., was able to reduce the award under the cap, but the plaintiff has appealed, claiming the cap is unconstitutional. The state Supreme Court will hear the case this fall.

**THE CONSTITUTIONALITY OF CAPS** has been challenged in several states, and the result has depended primarily on the

makeup of the state supreme court. Kansas passed a \$3 million cap on total awards, including a \$250,000 limit on noneconomic awards, in 1985. In 1988, a conservative state Supreme Court declared the entire cap unconstitutional, claiming it violated a person's right to trial by jury. The court held that only a jury had the right to determine damages.

Later that year, the Kansas Medical Society successfully lobbied for a \$250,000 cap on noneconomic awards. By 1989, the constitutionality of this cap, too, was challenged. But, this time the cap was upheld. In the interim, a new pro-tort reform governor had been elected, and several of his appointees supported organized medicine's position on caps.

Illinois physicians haven't

been so lucky. A \$500,000 cap on total damages passed in the mid-1970s was immediately thrown out by the state Supreme Court before it could ever be applied. Subsequent attempts to establish a \$250,000 cap on noneconomic damages have been defeated by the trial lawyers. ISMS considers passing a cap on noneconomic damages a priority.

In those states where the constitutionality of caps has not been questioned, medicine has, nevertheless, had to work hard to maintain them. Indiana legislators raised the state's cap from \$500,000 to \$750,000 in 1990 to adjust for inflation, a move the Indiana State Medical Association "thought was fair," said Adele Lash, an association spokesperson. The state bar has since asked for another

increase, to \$1 million. Indiana physicians will fight that, Lash said, because it jeopardizes the balance between medical care and the right to receive compensation when injured, which INCAP was designed to maintain.

Despite the ongoing controversy over caps, the public's response to them has been overwhelmingly favorable. A July public opinion poll of Massachusetts residents found that nearly 55 percent believe too much money is being awarded for malpractice. Massachusetts has had a \$500,000 cap on pain and suffering since 1986.

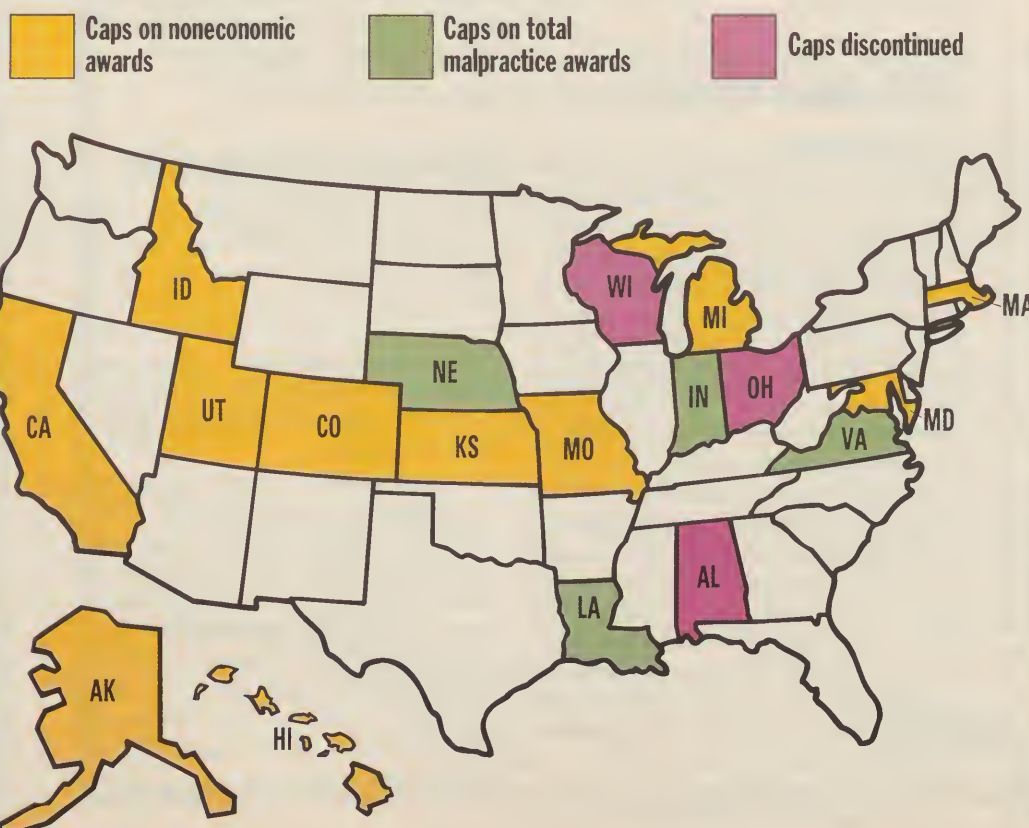
**ILLINOISANS SHARE** those sentiments. In a recent Gallup survey, 53 percent of the respondents said malpractice awards are "usually too high," and 70 percent agreed that there should be a cap on noneconomic awards.

The fight for caps has not been easy. "I feel like a soldier in the trenches, and I've just run out of bullets, and the enemy's still coming," said J. Leon Sorenson, executive vice president of the Utah Medical Association. But the state's \$250,000 cap on noneconomic awards has paid off.

Utah malpractice insurers have never paid more than that amount to compensate plaintiffs for pain and suffering. "We never had a pain and suffering award above \$250,000 [before the cap was passed in 1986], which made it easy to get [the cap] passed," Sorenson said. And even though claims in recent years have sought more than that amount, insurers have been liable only for amounts up to the cap plus any monies for economic losses.

Wisconsin also realized the potential for cost savings before its 1986 \$1 million cap on noneconomic awards was repealed in 1991 under a sunset provision. In the 1990 case of *Ready vs. Yap*, Wisconsin courts imposed the state's cap, reducing the jury award by roughly \$8 million. The jury originally awarded the plaintiff a total of nearly \$25 million, of which almost \$9 million was for pain and suffering. ■

### Caps on malpractice awards\*



Original Source: American Medical Association.

\*As of August 4, 1992



# Physicians shoulder responsibility for physician assistants

**LIABILITY:** Supervising physicians are responsible for all physician assistant activities and could be liable for their actions.  
By Anna Brown

[ CHICAGO ] In the last few years, very few complaints have been filed against physician assistants, according to the Illinois Department of Professional Regulation. The Illinois State Medical Inter-Insurance Exchange reports it has had to defend few cases involving physician assistant negligence. In Illinois, physician assistants and their supervising physicians are working well together, providing competent, timely patient care. However, physicians who use PAs should know their responsibilities.

"Physicians who employ physician assistants need to be aware that they are responsible for the actions of all their paramedical employees, including PAs," said Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors. "Illinois physicians are very careful and understand their responsibilities, which has steered them free from claims involving physician assistants. We commend these efforts and hope physicians will continue to strive for such excellence."

The Exchange does not issue policies to physician assistants; however, these professionals may be covered only as paramedical employees of policyholders. If an employee is sued, the policyholder may also be named in the suit.

"When a suit is filed for physician assistant negligence, often the PA will be dismissed from the suit altogether," Dr. Boren said. "The plaintiff knows the

physician holds the policy, and that's where the money is."

Under Illinois law, physician assistants must be certified by the National Commission on the Certification of Physician Assistants. They are permitted to perform a wide variety of procedures, provided there is one-on-one physician supervision.

According to Sheila Muldin, registrar for the National Commission, 46 states require certification. To be certified, applicants must graduate from accredited physician assistant programs, pass a certifying exam initially and then every six years, and complete 100 hours of CME credit every two years. The National Commission does not determine what procedures PAs may perform. "That is totally governed by each state," Muldin said.

The Illinois Physician Assistant Practice Act of 1987 states that physician assistants' role is to "augment the supervising physician's data gathering abilities to assist ... in reaching decisions and instituting care plans," and they may perform "only such procedures and other tasks as are usually performed within the normal scope and characteristics of the supervising physician's practice."

"PAs may perform many procedures within their supervising physicians' specialties," said Dr. Boren. "Physicians should take into consideration that some procedures may fall into a 'gray area'



WM. DANIELS/THE PHOTO PARTNERS

**SPEAKERS ARE NOW AVAILABLE** to address your clinic/office, hospital medical staff or local medical society on risk management topics. Members of the newly formed Exchange speakers' bureau listen to advice on public speaking from Gail Lovinger (right), of Max Russell and Associates. Eleven physicians completed the first set of speaker training sessions.

not specified in the law. Lawsuits can occur when patients don't feel completely comfortable with the care they receive."

Doctors who employ physician assistants recommend considering a PA's level of experience and working with him or her to develop specific office protocol. These steps may help to prevent incidents.

The American Medical Association's 1991 *Allied Health Education Directory* reports that just under half of physician assistant graduates work with family physicians and internists, but they can be found in a wide range of health care settings including hospitals, academic medical centers, HMOs, military facilities

and prisons.

"Physician assistants in our clinic feel comfortable going to any physician with questions," said Sharon Smaga, M.D., of the Family Practice Center in Carbondale, a Southern Illinois University-affiliated family practice residency program that employs two PAs. "Even so, each PA has a supervising physician. They see patients six to seven half-days a week, performing well baby care and school physicals, and they are in charge of the nursing staff. They do not perform many clinical procedures because we have residents, but they could."

Dr. Smaga knows she and other supervising physicians are liable for their PAs, but she said she has not had any patient complaints and feels confident about their skills. "It's important to know what a PA has done before, and most important is to set up protocols and put them in writing."

## MALPRACTICE ROUNDUP

### Medical record maintenance essential

In more than half of all claim payments, physicians' medical records are deemed inadequate, reported *An Ounce of Prevention*, the quarterly newsletter of the Medical Mutual Insurance Company of North Carolina. In its winter 1991 issue, it advises physicians to keep original records in their possession, allow patients access to their records in accordance with state laws, and release records to attorneys only when the physician at risk personally reviews the request or the request is accompanied by a written authorization from the patient.

The newsletter also recommends that physicians contact their professional medical liability insurer immediately if the purpose of the request is to evaluate a potential legal action against the physician or if a court order is filed.

Physicians also should remember to provide patients with written instructions for post-treatment and continuing care. *An Ounce of Prevention* advises periodic review of all records

to check for accuracy, objectivity, legibility, timeliness, comprehensiveness and alterations. ■

### AIDS claims expected to increase

The Physician Insurers Association of America reports that as more people are infected with HIV, more hospitals and physicians will face lawsuits. At its recent annual meeting, PIAA lawyers said that AIDS suits are extremely appealing to the plaintiffs' bar, and even though relatively few cases have come to trial, they can warrant huge verdicts against physicians.

The verdicts are "far beyond what anyone would ever be paid in the normal kind of lawsuit," said San Francisco defense attorney Duncan Barr at the PIAA annual meeting. "They [plaintiffs] know that the return on such cases is great, and they have come to see that the physicians and hospital cannot merely rely on the traditional standard of care in defending them."

The PIAA lists several areas of exposure to potential liability involving

AIDS, including release of AIDS information by medical personnel; failure to release AIDS information; failure to obtain informed consent to test for HIV; and denial of access to care. ■

### Prior care criticism risky

Patients take casual remarks about previous care very seriously, says the Risk Management Foundation of the Harvard Medical Institutions Inc. in its *Forum* newsletter. Physicians can alleviate misunderstandings and potential lawsuits by avoiding finger pointing in conversations with patients and in medical records.

Because medical records can reflect inconsistencies among patients' health care teams, *Forum* says oral or written criticism of previous care can lead to malpractice claims even if no negligence occurs. Although complete prior care records are difficult to obtain, physicians can take precautions by accurately and objectively documenting treatment from the time they assume patient care. ■

## When and how to reach ISMIE

Office hours for the Illinois State Medical Inter-Insurance Exchange are 8:30 a.m. to 4:45 p.m., Monday through Friday.

You may reach the Exchange staff during working hours at (312) 782-1654, (312) 782-2749 or in Illinois, (800) 782-ISMS.

The fax numbers are reception, (312) 782-2023; policyholder relations, (312) 782-0198; underwriting, (312) 782-0198; claims, (312) 782-0199. ■



# Getting started with the Exchange

**NEW APPLICATIONS:** Exchange new business is processed quickly and efficiently to eliminate physician hassle. By Anna Brown

[ CHICAGO ] Renewal periods are busy times for the Illinois State Medical Inter-Insurance Exchange, but processing new applications is always a top priority. For physicians, the application process can be a seamless experience. The Exchange provides all application materials including brochures and booklets detailing its coverage programs, as well as a checklist to ensure a complete application.

"At the Exchange, we want to make it as easy as possible for you to join us," said Harold L. Jensen, M.D., chairman of the Exchange Board of Governors. "As the oldest physician-owned malpractice insurance carrier in Illinois, the

Exchange has been bringing quality service and aggressive defense techniques to our policyholders since the mid-1970s. Our philosophies continue to prove sound as we move into the next decade."

When physicians apply to ISMIE for coverage, the Exchange screens each applicant and assigns an underwriter to process the application. The underwriter

confirms licensure, verifies membership with the county medical society, and reviews previous carrier records, going back 10 years. The physician completes Claim Experience Verification Letters – found in the "A Cornerstone of Security" application kits – and mails them to previous carriers, who verify loss history and return the forms to the physician. For the most part, underwriters say, this part of the process can take the most time.

Next, the Exchange verifies practice relationships and hospital affiliation. Rating classification is determined based on specialty training and procedures being performed. These are the main fac-

tors in determining the appropriate premium.

Many applications are processed very rapidly – one day is the record, underwriters say. The average time for a physician to apply for and receive coverage is about four weeks. In some cases the application process takes longer and requires more intense review. Nevertheless, the Exchange Underwriting Division makes every effort to see that the application process is completed as quickly and smoothly as possible.

To obtain an application kit, contact the Exchange Underwriting Division at (312) 782-1654, (312) 782-2749 or (800) 782-ISMS.

## EXCHANGE Q & A

**Q: My employer is a medical corporation insured with the Exchange. Am I insured by my employer or by the Exchange?**

**A:** If your employer has not purchased a policy naming you – not the corporation – as the policyholder in addition to the corporate policy, you are not insured. In order to be insured by the Exchange, physicians must have individual policies, except under a clinical policy. If you are an employee or a member of an Exchange-insured medical partnership/corporation, your premium may be paid by the group. Separate policies are issued for each physician in the group, as well as for the corporation itself. Each physician is individually insured and must meet the responsibilities of the policy, regardless of who pays the premium.

**Q: Does ISMIE provide any educational materials on the litigation process?**

**A:** Yes, the Exchange offers many services to prepare physicians for litigation. Educational materials range from brochures and videotapes outlining the various stages of the process, to personal support programs dealing with the stress of being sued. If a policyholder is sued, a professional liability analyst is assigned to the claim. The analyst and defense attorney work as a team that fully involves and supports the physician throughout the process. The Exchange's Physician Support Group is available to answer questions from physicians who have been sued and their spouses. To obtain a list of available materials, contact an ISMIE professional liability analyst or the risk management department at (312) 782-2749 or (800) 782-ISMS.

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A DAY IN THE LIFE

# Future physicians get a taste of real-life medicine

*High school students observe doctors on the job, learning firsthand what a career in medicine is all about.*

BY RACHEL BROWN

**D**uring rotations at Good Shepherd Hospital in Barrington, 17-year-old Emily Dodds saw seven babies delivered, scrubbed up with surgeons before accompanying them to the operating room and witnessed the deaths of two hospital patients. As part of the "Future Physicians" program, Dodds joined nine other area high school students this summer in experiencing various medical professions and specialties firsthand.

The program, founded by Richard C. Smith, M.D., an Ob/Gyn at Good Shepherd, allows students to rotate through several hospital departments such as orthopedic surgery, pediatrics, family practice and cardiology, during a six-week summer session.

"Ever since junior high school I wanted to be a pediatrician," said Sarah Pitluck, another program participant and a senior at Crystal Lake South High School. "But it is great to learn about other [areas of medicine]."

The Good Shepherd program, now in its second year, was organized "to bolster better relations between the community and hospital" and to give students an overview of the health care profession, said Dr. Smith.

"This program helped me decide to be a doctor. Before [the program] I didn't know what I was getting into," said Dodds, who will begin her senior year at McHenry High School's east campus this fall.

In contrast, Richard J. Ferolo, M.D., a participant in the Good Shepherd program, believes that for teens who are hesitant to enter the profession, the program may confirm their doubts.

"These programs are a good opportunity for students to see what goes on and say, 'This is not for me,'" said Dr. Ferolo, a Barrington family physician.

This year's 10 student participants, chosen from a pool of 180 applicants, were selected according to their grades, class rank, extracurricular activities and a personal interview with a hospital selection committee, said Dr. Smith. For their participation, students receive a \$1,000 stipend after the six-week session.

Due to the program's popularity, Dr. Smith is developing a planning guide for other hospitals to use in organizing similar "hands-on" educational programs for students.

St. Francis Medical Center in Peoria recently completed the first of two weeklong medical careers sessions for area students. Similar to the Good Shepherd program, the "Scrub Club" sessions allow students to rotate throughout various hospital departments, observing hospital personnel and practicing specific skills.

In this program, however, physicians play a minor role. Students meet with nutritionists, physical and occupational therapists, nurses and finally physicians,



**Sarah Pitluck, a senior at Crystal Lake South High School, scrubs up before entering the operating room at Barrington's Good Shepherd Hospital. Pitluck was one of 10 student participants chosen from a pool of 180 applicants.**

CHIP ZELLET



## A DAY IN THE LIFE

CHIP ZELLET



At right: Emily Ruminski, a senior at Harry D. Jacobs High School in Algonquin; Sarah Pitluck; and Michael Moore, a senior at Barrington High School in Barrington, observe surgeon Robert C. Witkowski, M.D., and anesthesiologist Bradley Schnack, M.D., as they perform surgery at Good Shepherd Hospital.

learning how all areas of the hospital work together in patient care.

Richard L. Horndasch, M.D., a physician participant and director of the UIC College of Medicine at Peoria's medicine/pediatric residency program believes the program's format works for students as they learn how hospital personnel interact and how doctors rely on the staff's expertise in developing treatment plans.

Ancillary health careers are also the focus of the "Explore Nursing Club" at Decatur Memorial Hospital. Through the club, which meets the first Monday of each month, 200 students have visited the Ob/Gyn, intensive care and oncology departments and have heard presentations and participated in demonstrations from paramedics and emergency room personnel, said Laura Reedy, R.N., a member of the personnel committee that coordinates the program.

"We explore all areas because we feel if we can't get the students into nursing, we can keep them in the health care field," explained Reedy.

**THE HANDS-ON APPROACH** of these programs differs from the observational "Day With a Doc" program at UIC College of Medicine at Peoria. For the past two years, the college has offered the program to high school sophomores and juniors who have an "itch" to be physicians, said Lori Lucas, community relations assistant at the college.

Sponsored by the department of family medicine, the program has given 25 area students the chance to "see what a day in the life of a doctor is really like," said Lucas.

Due to increasing student interest, the program was expanded from half- to full-day sessions after its first year, said Gregory Clementz, M.D., chairman of the department of family medicine at the college. In addition, eight physicians have volunteered to sponsor students; only three doctors were involved last year.

Dr. Clementz has sponsored six students since the program's inception and is encouraged by the program's expansion and its focus on primary care.

"There is a lot of talent out there in the rural areas," said Dr. Clementz. "Physicians need to establish themselves as role models and encourage these students to continue with medicine."

Although many of these programs target teenagers who are considering medical careers, seven medical schools in Chicago have banded together to focus on col-

lege-age minority students who have already decided to attend medical school.

The medical schools, participants in the Chicago Area Health and Medical Careers Program, sponsor minority students for six weeks every summer in intense medical school preparatory courses and activities, said Reggie Jones, Ph.D., director of the program.

The citywide program was developed four years ago to increase the number of minority students entering the medical field as well as to prepare them for the rigors of medical school and practice, said Dr. Jones.

"The purpose of this program is to get qualified minority students and give them one last fine tuning ... to make them even more qualified for medical school," explained Edward Eckenfels, director of the program at Rush Medical College, one of the participating schools.

Rush Medical College joined the University of Chicago's Pritzker School of Medicine, Chicago Osteopathic Medical Center, University of Health Sciences/The Chicago Medical School, University of Illinois at Chicago's College of Medicine, Loyola University's Stritch School of Medicine and Northwestern University's School of Medicine, in educating more than 115 students this summer.

Forty-three participants in Rush's program spent six weeks attending courses in anatomy, biochemistry and quantitative analysis, and spending time at Cook County Hospital and free clinics, said Eckenfels, a professor of preventive medicine at the college. In addition, Eckenfels teaches verbal reasoning and patient communication.

The courses at Rush and other programs around the state encourage students to ask questions and prepare them for the reality of a medical career, said Eckenfels.

"[These programs] give a realistic view of what medicine is like," said Dr. Clementz, from the "Day With a Doc" program. "There are a lot of negatives out there with malpractice and increasing paperwork, but if kids really see the positives, that will encourage them to continue with medicine."

Darchelle Comber, a Good Shepherd program participant from Barrington, believes these positive experiences include improving physician-patient relationships. "I learned that what makes a good doctor is not so much the skills, but how doctors treat their patients." ■



DUANE ZEHR

Tanya Wilson (left) of Creve Coeur and Joni Barth (right) of Pekin look on as Donald H. Blair, M.D., of Tremont gives 11-month-old Nicholas Barth a routine check-up.



## IDPR DISCIPLINES

*This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.*

**November 1991**

Bungorn Boonsurmsunongse, Taft, California – physician and surgeon license suspended indefinitely after California license was disciplined for unprofessional conduct, including acts

of gross negligence and incompetence.

Tri D. Nguyen, St. Louis, Missouri – physician and surgeon license revoked after California license was disciplined for gross negligence and incompetence.

Donald Shanklin Wham, Carbondale – physician and surgeon license reprimanded and controlled substance license suspended for two years after authorizing prescriptions for employee

and her family without conducting proper work-ups, maintaining appropriate records, and adequately monitoring amounts prescribed.

Sigmund Warren Konarski, Fairfield – physician and surgeon license reprimanded and controlled substance license placed on probation for two years after failing to maintain controlled substances dispensing records. May have failed to offer written pre-

scription to patients prior to dispensing medications.

Kenneth M. Newman, Chicago – physician and surgeon license reprimanded and fined \$1,000 after practicing on nonrenewed license.

Caroline Brown, Lombard – physician and surgeon license reprimanded and fined \$800 after practicing on nonrenewed license.

Tighe E. Zimmers, Chicago – physician and surgeon license reprimanded and fined \$500 after practicing on nonrenewed license.

**December 1991**

Ricky S. Pionkowski, Champaign – physician and surgeon license reprimanded and fined \$800 after practicing on nonrenewed license.

David M. Terman, Chicago – physician and surgeon license reprimanded and fined \$500 after practicing on nonrenewed license.

Charles H. Shaiova, Chicago – physician and surgeon license placed on probation for one year and fined \$1,700 after practicing on nonrenewed license.

Robert H. Lee, Country Club Hills – physician and surgeon license suspended indefinitely after Kansas State Board disciplined license for negligence in quality of care.

Oscar E. Munoz Andrade, Chicago – physician and surgeon license reprimanded and fined \$500 after practicing on nonrenewed license.

Martha F. Hernandez, Chicago – physician and surgeon license renewed and placed on probation until satisfactorily completing repayment of Illinois educational loan.

**January 1992**

Richard S. Cook, Chicago – controlled substances license suspended pending proceedings before Department.


**February 1992**

Nathan Joseph Averick, Chicago – medical license reprimanded and fined \$500 after practicing on nonrenewed license.

Ofelia Bernabe, Cahokia – medical license placed on probation and controlled substances license suspended indefinitely after State of Missouri licenses disciplined.

Beatrice A. Nelson, Chicago – medical license reprimanded and fined \$1,700 after practicing on nonrenewed license.

James R. Luchs, Compton, California – medical license revoked following California revocation after engaging in illegal sales and distribution of triplicate prescriptions and controlled substances.



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## East St. Louis resumes trash collection

**PUBLIC HEALTH:** City cleanup resumes after seven years.

By Anna Brown

[ EAST ST. LOUIS ] Citizens of East St. Louis stopped throwing their trash in vacant lots and abandoned buildings last month, when the city reinstated a regular trash collection program, on hold since 1985. The city's Aldermanic Council approved a \$3.6 million, three-year contract with Waste Management, a private hauler.

"We are elated to begin trash pickup again," said Don Brannon, director of environmental health for the East Side Health District. "This will bolster the esteem of the people of East St. Louis. It was a real thorn in our side to see children playing in dumps."

Since 1985, about two-thirds of the population had been illegally dumping

trash, Brannon said. Some contracted individually with small private haulers, but these haulers often dumped the trash in vacant lots.

"It became a nightmare," Brannon said. "People were throwing trash everywhere. We saw a considerable increase in disease vectors, such as mosquitos around dumped trash and tires. The rat population also increased."

"The place is already beginning to look better," said Charles Frazer, M.D., an East St. Louis physician. "The trash has been a source of contagion, breeding vermin and mosquitos. We're taking a positive step in the city's overall attitude

toward cleanliness."

Although he could not link his patients' health problems directly to trash, Dr. Frazer said he has seen many cases of gastroenteritis in the last few years.

Pickup ended in East St. Louis when the city could not pay hauling bills. Brannon said community groups had worked with the city and the state for several years to fund the new program. Citizens must also pay a fee to the city. ■

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## OBITUARIES

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

#### \*\*Armstrong

Wilber P. Armstrong, M.D., of Springfield, died February 14, 1992, at the age of 93. Dr. Armstrong was a 1923 graduate of Harvard Medical School, Boston.

#### Burnell

Irving Burnell, M.D., of Augusta, died March 13, 1992, at the age of 73. Dr. Burnell was a 1945 graduate of Chicago Medical School.

#### \*\*Dominski

Anthony V. Dominski, M.D., of La Grange Park, died April 29, 1992, at the age of 80. Dr. Dominski was a 1939 graduate of Chicago Medical School.

#### \*\*Fliesser

Werner Fliesser, M.D., of Hoopeston, died February 5, 1992, at the age of 81. Dr. Fliesser was a 1937 graduate of Friedrich-Wilhelms Universitaet Medizinische Fakultät, Berlin, Germany.

#### \*\*Heskett

Byford F. Heskett, M.D., of Chicago, died March 25, 1992, at the age of 92. Dr. Heskett was a 1930 graduate of Northwestern University Medical School.

#### \*Hill

John P. Hill, M.D., of Harvard, died March 31, 1992, at the age of 64. Dr. Hill was a 1952 graduate of Northwestern University Medical School, Chicago.

#### \*Hussey

Frank Hussey Sr., M.D., of Wilmette, died February 20, 1992, at the age of 93. Dr. Hussey was a 1924 graduate of Northwestern University Medical School.

#### \*Hyde

John S. Hyde, M.D., of River Forest, died May 1, 1992, at the age of 73. Dr. Hyde was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

#### \*Katopodis

Spyros Katopodis, M.D., of Palos Park, died February 25, 1992, at the age of 63. Dr. Katopodis was a 1955 graduate of the Faculty of Medicine of the Aristotelian National University of Athens, Athens, Greece.

#### \*\*Langston

Hiram Langston, M.D., of Savannah, Ga. (formerly of Riverside), died May 15, 1992, at the age of 80. Dr. Langston was a 1934 graduate of the University of Louisville School of Medicine, Louisville, Ky.

#### \*\*Latimer

Earl O. Latimer, M.D., of Peoria, Az. (formerly of Evanston), died December 30, 1991, at the age of 89. Dr. Latimer was a 1928 graduate of Rush Medical College, Chicago.

#### \*\*Loewinsohn

Erhard Loewinsohn, M.D., of Chicago, died March 31, 1992, at the age of 82. Dr. Loewinsohn was a 1937 graduate of Medizinische Fakultät der Universität Bern, Bern, Switzerland.

#### \*\*Meyer

Samuel J. Meyer, M.D., of Highland Park, died April 5, 1992, at the age of 95. Dr. Meyer was a 1924 graduate of Rush Medical College, Chicago.

#### \*Miller

Robert G. Miller, M.D., of Chicago, died February 17, 1992, at the age of 65. Dr. Miller was a 1953 graduate of the University of Illinois College of Medicine, Chicago.

#### \*\*Nesbitt

Marjorie R. Nesbitt, M.D., of Elgin, died January 10, 1992, at the age of

87. Dr. Nesbitt was a 1933 graduate of the Loyola University Stritch School of Medicine, Maywood.

#### \*Pruc

Jeremias N. Pruc, M.D., of Northbrook, died March 14, 1992, at the age of 70. Dr. Pruc was a 1949 graduate of Universitaet Graz, Medizinische Fakultät, Graz, Austria.

#### \*\*Reaney

Burnell V. Reaney, M.D., of Highland Park, died December 15, 1991, at the age of 82. Dr. Reaney was a 1937 graduate of Rush Medical College, Chicago.

#### Rodriguez

Guillermo Rodriguez, M.D., of Collinsville, died April 8, 1992, at the age of 57. Dr. Rodriguez was a 1959 graduate of Facultad de Medicina, Universidad de Panama, Panama.

#### \*\*Runde

Raymond H. Runde, M.D., of Peoria, died February 7, 1992, at the age of 91. Dr. Runde was a 1930 graduate of St. Louis University School of Medicine, St. Louis.

#### \*Stipak

Emil P. Stipak, M.D., of Chicago, died February 1, 1992, at the age of 70. Dr. Stipak was a 1945 graduate of the Loyola University Stritch School of Medicine, Maywood.

#### \*Sutton

George C. Sutton, M.D., of Evanston, died April 7, 1992, at the age of 71. Dr. Sutton was a 1945 graduate of Northwestern University Medical School, Chicago.

#### \*Trotta

Julio E. Trotta, M.D., of Lombard, died April 28, 1992, at the age of 63. Dr. Trotta was a 1953 graduate of the College of Medicine, University of the Philippines, Manila.

#### \*Vil

Charles S. Vil, M.D., of Flossmoor, died January 12, 1992, at the age of 71. Dr. Vil was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

#### \*\*Wasserman

Reuben R. Wasserman, M.D., of Pompano Beach, FL (formerly of Chicago), died February 28, 1992, at the age of 79. Dr. Wasserman was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

#### \*\*Wyman

George J. Wyman, M.D., of Peoria, died April 14, 1992, at the age of 77. Dr. Wyman was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

#### \*Zielinski

Victor J. Zielinski, M.D., of Chicago, died January 22, 1992, at the age of 77. Dr. Zielinski was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

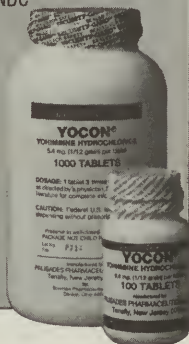
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## Patients are more aware of advance directives, but physicians could play a larger role

**ADVANCE DIRECTIVES:** Physicians should do more in counseling patients on advance directives, ethicists say. By Kevin O'Brien

[ CHICAGO ] In the nine months since the federal Patient Self Determination Act (PSDA) went into effect, patients entering hospitals seem to be more aware of their rights regarding advance directives. But experts also note that physicians could do more to help their patients understand this complex situation.

"Physicians still are generally not asking patients about advance directives and their goals for end-of-life treatment," said John J. LaPuma, M.D., director of the Lutheran General Hospital Center for Clinical Ethics in Park Ridge. "These discussions really need to occur in the physician's office first, not wait until the patient is admitted to the hospital."

That most patients were not addressing this issue until they were hospitalized is what led Congress to pass the PSDA in October 1991. Effective Dec. 1, 1991, the PSDA required hospitals, nursing homes, hospices, managed care organizations and home health agencies to advise patients of their right to accept or refuse medical care and to execute an advance directive. In addition, hospitals must provide information about state laws and the hospitals' policies on such written advance directives as living wills and durable powers of attorney.

"We've noticed an increasing number of people who have some sort of advance directive," said John D. Lantos, M.D., associate director of the Center for Clinical Medical Ethics at the University of Chicago and chief of staff at LaRabida Children's Hospital and Research Center in Chicago. Dr. Lantos said most patients who arrive at the University of Chicago Hospitals with executed advance directives seem to have done so at their own initiative. In any case, he said, the PSDA is being implemented in most hospitals by hospital staff, not in the doctor's office.

Dr. LaPuma cites three reasons for physician reluctance to tackle the subject. First, doctors have previously viewed advance directives as a patient responsibility. Second, physicians have been generally uncomfortable discussing the possible limitations of treatment, unless the patient brings it up. Finally, younger, healthy patients and their physicians have traditionally viewed advance directives as being necessary only for elderly or critically ill patients.

Even when patients talk to their physicians about advance directives, adds Dr. LaPuma, most patients don't take the next step and write down what they want. "The last data I saw was about 10 percent of patients have signed advance directives of some kind."

Dr. Lantos notes that physicians need to counsel their patients on the appropriate use and limitations of advance directives. That means they must educate themselves. "Physicians need to understand what makes a good advance directive in terms of the patient's wishes and what makes a bad one."

He said that any advance directive has a procedural component, addressing *who* will make decisions in the event the patient becomes incompetent and a substantive component dealing with *what* those decisions should be.

"Different people want different degrees of procedure and substance," Dr. Lantos said. "Some people have a very firm idea about when they wouldn't want life-sustaining treatment, and if they do, they should specify those. I think it's more common that people know who they want to make decisions for them if they become incompetent. And if so, they should give that person as much freedom as they can."

Both experts agree that discussing

advance directives should become a routine part of patient care, no matter how young or healthy the patient is. "These discussions are important and do yield results," said Dr. LaPuma. "They promote the discussion of patient goals and values in health care, which we often don't ask about but need to."

"I think you can carry it to an extreme [with asking] the 18-year-old during their college physical," said Dr. Lantos. But he advocates regular discussions

with patients in their 30s, 40s or 50s. "The message from doctors would be, 'It's important for us to talk about this periodically. And if you don't want to talk about it now, that's fine, but I'm accessible.'"

*The Illinois State Medical Society has brochures explaining advance directives for physicians and patients. For more information, call ISMS at (312) 782-1654 or (800) 782-ISMS.*



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**Maudie M. Miller, M.D.**  
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**Prentiss B. Taylor, M.D.**  
Pulmonary specialist, Chicago

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*Interviews by Anna Brown and James B. Haverstick*

PHOTOS BY MICHAEL CANDEE AND MAUREEN HOUSTON

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## If you haven't yet registered to vote, do it now

(Continued from page 1)

chamber against each other. In Illinois, it also has resulted in the possibility that Senate control could revert to the Republicans after 10 years of Democratic control.

"In 1992 Americans will elect legislators in newly drawn political districts nationwide," said Pam Taylor, ISMS Auxiliary legislative affairs chairman. "Those we elect to represent us at all levels of government will most likely be incumbents for the next decade and will continue to shape health care policy and law. It is vitally important that everyone qualified to vote does register and vote no matter what their political party affiliation may be."

To register you must be a resident of the state and precinct in which you intend to vote 30 days prior to the election. Illinois citizens have until Oct. 5 to register.

"County clerks are the official registrars in the state, and they all have

appointed deputy registrars in libraries and other public and private agencies throughout their counties," said a spokesman for the State Board of Elections.

To find out where to register, call your county, municipal or township clerk. Aside from the 102 Illinois county clerks, all township and municipal clerks are by law deputy registrars. Nine Illinois communities - Aurora, Bloomington, Chicago, Danville, East St. Louis,

Galesburg, Peoria, Rockford and Springfield - also have city boards of election commissioners.

**THANKS TO THE ISMS AUXILIARY**, Illinois physicians need only look to their county auxiliary to find a deputy registrar. The Auxiliary is again coordinating a statewide voter registration campaign. Voter registration informational materials were sent out in early July to all county auxiliary presidents and legislative chairs, and all county medical society presidents, secretaries and executives.

"Previously sponsored ISMSA and county medical society auxiliary voter

registration drives have been very successful," said Auxiliary President Carol Gapsis. "It is important that we equal or better that success this coming year."

At press time, 22 Auxilians in 10 counties had signed up to help register new voters in their counties. They have planned special registration days at county medical society meetings and at local hospitals. Auxiliary officials urge all county auxiliaries that have not already done so to organize similar drives. ■

## Compliance procedures

(Continued from page 1)

you have made refunds to beneficiaries where overcollection may have occurred." Physicians whose charges do not exceed the limiting charge will not receive an LCER.

Physicians who receive an LCER must make an appropriate refund within 30 days of receipt. Physicians who believe that an error occurred on the claim as submitted or that the carrier made an error in processing the claim may submit clarifying information for Blue Cross review. However, if the carrier still concludes the charge exceeded the limiting charge, the physician must make the refund within 15 days of being notified of the carrier's decision.

Blue Cross said the traditional method of monitoring limiting charge compliance based on six-months of claims history "caused confusion for beneficiaries and physicians." The new compliance program is intended to provide more timely information to physicians and beneficiaries.

But the changes were also in part prompted by a lawsuit against HCFA brought by several beneficiary groups and by an April 8 hearing held by the Senate Special Committee on Aging. The American Medical Association testified at the hearing that it supported enforcement programs that are "flexible and incorporate due process protections for physicians who may have exceeded the charge limits." The AMA also said that "all evidence indicates that the number of violations is extremely small."

The Blue Cross letter refers physicians with questions about the program to Tandra Parks at (618) 997-3190 or Blue Cross at P.O. Box 4422, Marion, IL 62959. In addition, the Illinois State Medical Society will monitor the program's implementation in Illinois and nationwide. Physicians with questions should call the ISMS Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. ■



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# Public Aid audits recover millions in Medicaid funds

**MEDICAID PROVIDERS:** Large recoveries resulted from IDPA fiscal audits of hospitals, pharmacies, labs and nursing homes during 1992. By Anna Brown

[ CHICAGO ] Audits of Illinois medical providers during fiscal year 1992 allowed the Illinois Department of Public Health to recover \$21.4 million in Medicaid funds, the department announced July 29. The record recovery represents a leap of more than 100 percent from the previous year, which the department attributes to improved auditing techniques. IDPA held 165 on-site audits of Medicaid providers, and 24 were terminated from the program, including four pharmacies, four laboratories and an ambulance company.

Of the 165 fiscal audits performed by the department's Bureau of Medical Quality Assurance, almost every investigation resulted in recovery of some kind, said IDPA spokesman Karl Piepenburg. Some were small, he said, averaging about \$300, but others were in the \$300,000 range.

"These recoveries were not all necessarily fraud," Piepenburg noted. "Some resulted from misunderstandings and bookkeeping errors."

The collected monies include \$6.77 million in actual collections and \$3.48 million in credits against funds that

would have been paid to medical providers. The total also includes \$11.15 million that will be charged against future payments to institutional providers, the department said.

*Of the 165 fiscal audits performed by the IDPA's Bureau of Medical Quality Assurance, almost every investigation resulted in recovery of some kind.*

"Medicaid serves 1.3 million people in Illinois and requires quality care and integrity from medical providers," said IDPA Director Phil Bradley in announcing the recoveries. "We constantly work to make sure each tax dollar appropri-

ed for Medicaid goes to help someone in need."

"It is important to note that the vast majority of providers in Illinois are 100 percent above board," Piepenburg said. "This collection frees up money to pay those who are doing a good job."

The audits were either random or triggered by the department's computer system, Piepenburg said. The system performs periodic reviews to identify potential problem areas that could signal the need for an audit. IDPA employs 15 audit teams that spend days in hospitals, nursing homes, laboratories and pharmacies, checking billings and inventories, and matching claims sent to the department by providers.

Where violations are found, providers may be required to set up a repayment program or have their future Medicaid payments withheld, Piepenburg said. Others are terminated, and some may be referred to law enforcement authorities.

Questions about quality of care, rather than billing, generally trigger physician audits. The Department's Medical Quality Review Committee is responsible for audits of physicians, a separate process

in IDPA. Every year the department screens about 700 physician profiles that "fall out" of the system for any number of reasons. Of these, almost 90 percent are closed without further action. The remaining cases, about 85 in 1992, are reviewed by a panel of physicians charged with making recommendations to the department. The panel may recommend continued monitoring, may refer the case to CME, close the case without further action or recommend termination or suspension from the Medicaid program. Before physicians are terminated they are allowed a hearing by a peer review panel, Piepenburg said.

"The termination period lasts for one year, and all physicians have the right to a fair hearing and the appeal process," Piepenburg added.

Physicians may also be subject to fiscal audits, although these are less common than quality reviews. Fiscal audits of physicians are usually based on billing practices and may result in the department's recouping Medicaid payments. In cases involving fiscal audits, a re-audit is conducted before any determination of recovery is made.

Physicians with questions about the Medicaid audit procedure can contact the ISMS Division of Health Care Finance at (312) 782-1654. Future issues of *Illinois Medicine* will include information on responding to a Medicaid MQRC process and record management and documentation recommendations. ■

## Medicaid fraud

(Continued from page 1)

The individuals would provide a Medicaid card to their physicians to receive care for which they were ineligible, the government alleges. The doctor would have no way of knowing the person was defrauding the system, Dyer said. "As far as the physician was concerned, the person would be entitled to the care."

One of the cases was discovered through the IDPA fraud hot line, said IDPA spokesman Dean Schott. "Periodic

indictments such as these are positive in that they send a message that if you [commit fraud], you can be caught," Schott said.

"It's hard to put a finger on how big the overall fraud problem is," he said. "At any one time it's difficult to say. But we have auditors, peer review specialists and investigators who regularly look for waste and fraud in welfare spending."

Schott said the department regularly runs computer tape matches with the Department of Labor, the federal government and neighboring states to find any individuals who may be illegally col-

lecting benefits under more than one Social Security number. Other types of fraud are not as easy to detect. "Fraud is not often readily apparent if a person has created a completely fictitious identity," he noted.

IDPA urges anyone with information about possible Medicaid fraud to call the department's hot line at (800) 252-8903.

MEANWHILE, THE FEDERAL government is continuing its investigations of Illinois physicians, Dyer told *Illinois Medicine*. "We have a lot of cases of [possible] doctor fraud ongoing with the Health

Care Task Force of the FBI."

He stressed, however, that "health care [fraud] is not just doctors." The government also investigates equipment suppliers, nursing homes and hospitals, he said. "As far as physicians are concerned, we have cases on every type of physician from podiatrists to cardiologists to gynecologists."

Although there is no package of cases involving Illinois doctors scheduled to be announced, Dyer said, "I assure you we'll have a number of cases coming down during the year." ■



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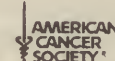
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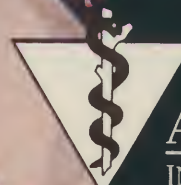
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# Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • AUGUST 28 1992

## STDs ON THE DOWNSWING IN ILLINOIS

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Illinois HIV  
situation

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## Oregon : A Medicaid expansion plan tagged with the 'R' word

**REFORM:** Is the Bush administration's refusal to provide federal waivers the kiss of death for Oregon's plan to expand access by rationing care?  
By Ginny Thiersch

[ CHICAGO ] When the Bush administration rejected Oregon's application for federal Medicaid waivers earlier this month, the state's bold experiment to expand access to Medicaid benefits teetered on the edge of failure.

The rejection, which the administration said was required because the plan violated the Americans with Disabilities Act, which became effective July 26 for most practices, caught most health care reform observers by surprise. Although Oregon may resubmit its waiver application, the state's experience makes it questionable that health care reform experiments at the state level can negotiate the political shoals of federal regulation and



BARBARA FRIEDMAN

the national lobbying efforts of special interest groups.

In returning the program to the state, U.S. Health and Human Services Secretary Louis W. Sullivan, M.D., urged Oregon to work with federal

officials to redraw the plan to satisfy the challenges from advocates for disabled groups. Anti-abortion groups also opposed the plan.

While the state could apply for congressional approval of the required waivers, strong opposition from congressional leaders like Rep. Henry Waxman (D-Calif.), chairman of the House Health subcommittee, and Democratic vice presidential candidate Sen. Albert Gore Jr. (D-Tenn.) make such an

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**OUTGOING AMERICAN MEDICAL Association Auxiliary President Sherry Strebel (left) presents Peoria Medical Society Auxiliary Health Promotions Chairman Kristy Gorenz and ISMS delegate Chester C. Danhower, M.D., with a Health Awareness Promotion Award at the AMA's 1992 annual meeting in June. See story, page 21.**

## Reform options weighed at Kane County conference

**REFORM:** Illinois congressman's panel debates single payer, play-or-pay and market-based reform options. By Anna Brown

[ ST. CHARLES ] Experts on three options for health care reform addressed a full house of physicians and other health care professionals, consumers and businesspeople Aug. 7 on the issue that dominated the presidential campaign that week. Chaired by U.S. Rep. J. Dennis Hastert (R-Batavia), a member of the Republican Leadership Task Force on Health Care Reform, the conference featured formal presentations on the single payer alternative, the play-or-pay option and market-based reform; a panel discussion of the options; and an address by Gail R. Wilensky, Ph.D., deputy assistant to the president for policy development and former head of the U.S. Health Care Financing Administration.

The Kane County Medical



**Rep. J. Dennis Hastert (R-Batavia) chaired the 1992 Illinois Conference on Health Care held Aug. 7 in St. Charles.**

Society and the Illinois State Medical Society were among the conference sponsors. Hastert asked KCMS to participate because of the good relationship it has developed with him over the years, said Ronald

(Continued on page 14)

### ON THE GOVERNOR'S DESK

## ISMS SEEKS ACTION ON HEALTH CARE LEGISLATION

[ CHICAGO ] The Illinois State Medical Society has asked Gov. Jim Edgar to take action on a number of bills affecting Illinois patients and physicians. Jere E. Freidheim, M.D., Chairman of the ISMS Board of Trustees, has urged the governor to sign into law a bill that would delete the requirement that physicians witness the execution of criminals sentenced to death. Although the bill does not remove the requirement that a physician pronounce death following an execution, ISMS recognizes the important step

toward removing physicians from the execution process completely, which enactment of this legislation accomplishes. Dr. Freidheim told the governor the bill is "of profound importance to the physicians of Illinois."

Citing potential harm to the public, ISMS has urged the governor to veto the Professional Counselor and Clinical Professional Counselor Licensing Act because it would allow individuals to provide human services beyond their training. The governor vetoed

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## Judge slashes Upjohn malpractice award

[ CHICAGO ] A Cook County Circuit Court judge slashed the record \$127.7 million malpractice judgment against the Upjohn Co. to \$38.1 million Aug. 14.

Judge Leonard L. Levin upheld the jury's October 1991 award of \$3.1 million in compensatory damages awarded to plaintiff Meyer Proctor of Oak Park but cut the \$124.5 million punitive damages award to \$35 million.

Proctor sued Upjohn, the manufacturer of Depo-Medrol, after the drug was injected into Proctor's left eye during treatment of chronic eye inflammation in 1983. Proctor subsequently lost sight in the eye, and it was removed. Proctor's physician, Michael Davis, M.D., an Olympia Fields ophthalmologist and co-defendant in the case, was acquitted by the jury. Dr. Davis is an Illinois State Medical Inter-Insurance Exchange policyholder.

The case involved an off-label use of the drug that Upjohn said was not recommended by the manufacturer. During the trial, Upjohn was accused of not advising physicians of possible side effects of the drug.

The jury award was a record for Illinois malpractice judgments. Upjohn still plans to appeal the jury's verdict. ■

## CLIA registration deadline is Sept. 1

[ CHICAGO ] The dark cloud no longer looms; it's right overhead.

As of Sept. 1, physicians who do laboratory testing in their offices but have not yet registered with the U.S. Health Care Financing Administration will be in violation of federal law.

Under the Clinical Laboratory Improvement Amendments of 1988, each physician conducting in-office laboratory testing is required to have a federally assigned CLIA number. Without it, physicians will be identified as noncompliant when they bill Medicare or Medicaid for a laboratory test, said Rebecca Friedman Zuber, chief of the Illinois Department of Public Health's Division of Health Care Facilities and Programs, which monitors CLIA compliance in Illinois. Information regarding a physician's compliance also will be available to private insurers.

"The message for physicians with labs who have not yet acted is take this seriously," said Zuber. "The sooner the process starts, the better. If a physician has not started the process by Sept. 1, he or she will be in violation of federal law."

Even physicians who perform simple laboratory tests in the office without charging the patient must register and obtain a certificate from HCFA. Physicians who completed the mandatory HCFA Form 109 lab survey should have received a certificate application and a billing coupon for the registration fee. Once HCFA receives payment of the registration fee, it issues the CLIA number.

The American Medical Association reported Aug. 6 that HCFA had received more than 90,000 CLIA registration forms nationwide but that only 44,000 labs had paid their registration fees and received a CLIA number.

Illinois physicians who have submitted their CLIA registration payment but

have not yet received their number should contact the Health Standards and Quality Bureau in HCFA's Chicago office at (312) 353-9805. Physicians with office labs who have not yet completed a HCFA Form 109 should do so at once. To receive a form, contact the Illinois State Medical Society Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. ■

## Federal funds provide hepatitis B vaccine for newborns

[ CHICAGO ] The Illinois Department of Public Health received federal funds to vaccinate 55,000 infants against the deadly and contagious hepatitis B virus.

The state received a grant of \$188,000 on July 1 to target all infants born outside Chicago after that date, according to IDPH spokesman Tom Schaffer. A separate grant was awarded to the Chicago Department of Health to vaccinate 20,000 infants within the city limits. In November 1991, the U.S. Centers for Disease Control recommended that newborns be immunized to curb the growing problem of hepatitis B.

Although all infants are targeted for vaccination, those born to mothers with a history of multiple sex partners or IV drug use are at the highest risk of infection, said Schaffer.

In 1990, 591 cases of hepatitis B infection were reported in Illinois, with the majority of cases reported in people 20-39 years old. Schaffer pointed out that although only two reported cases were in children under 2 years of age, it is much easier to immunize children than adults.

"It is easier to [vaccinate] a person at a younger age because older people tend not to see their doctor as regularly," he said.

Three shots, between birth and 18 months, are necessary for complete immunization. ■

## First Illinois arbovirus case confirmed in Sangamon County

[ SPRINGFIELD ] Illinois' first case of arbovirus infection for 1992 has been confirmed in Sangamon County, according to the Illinois Department of Public Health. The 9-year-old patient, whose acute and convalescent serum specimens showed a greater than fourfold rise in antibodies against California (LaCrosse) encephalitis, became ill July 7.

"Because this case provides solid evidence that an arbovirus and its vector are present in sufficient quantities to produce human illness in Sangamon County, we are asking local health departments in counties contiguous to Sangamon County to increase surveillance for human illness," said a notice distributed by the IDPH Division of Infectious Diseases.

Counties contiguous to Sangamon include Logan, Cass, Menard, Morgan, Macoupin, Montgomery, Christian and Macon. IDPH asks that local public health officials contact hospitals weekly during the arbovirus season, which could last until the first week in October, to inquire about patients with illnesses that are compatible with arbovirus infections. Such illnesses include aseptic meningitis, encephalitis and meningoencephalitis. ■

## Court rebukes Phelan for "hoax," orders hearing on executive authority suit

[ CHICAGO ] A Cook County Circuit Court judge Aug. 14 labeled a resolution supporting County Board President Richard J. Phelan's authority to reinstate elective abortions at Cook County Hospital a "hoax" and ordered the scheduled hearing to proceed.

During a special County Board meeting that morning, the board adopted 10-2 a resolution sponsored by Commissioner Danny Davis that "acknowledged" Phelan's June 18 executive order reinstating elective abortions at the public hospital. The resolution declared the order effective until the County Board adopts an alternate ordinance "signed by the president or passed over his veto."

The resolution never mentions abortion and seemed carefully crafted to confine the issue to executive authority. Theoretically, anti-abortion commissioners could vote with Phelan while retaining their anti-abortion credentials.

Later, attorneys for Phelan sought dismissal of a lawsuit brought by five county commissioners challenging the executive order on the grounds that the board's action rendered the case moot. Saying, however, the resolution "turns the legislative process on its head," Circuit Court Judge Thomas J. O'Brien rejected the motion and ordered the scheduled Aug. 18 hearing to proceed.

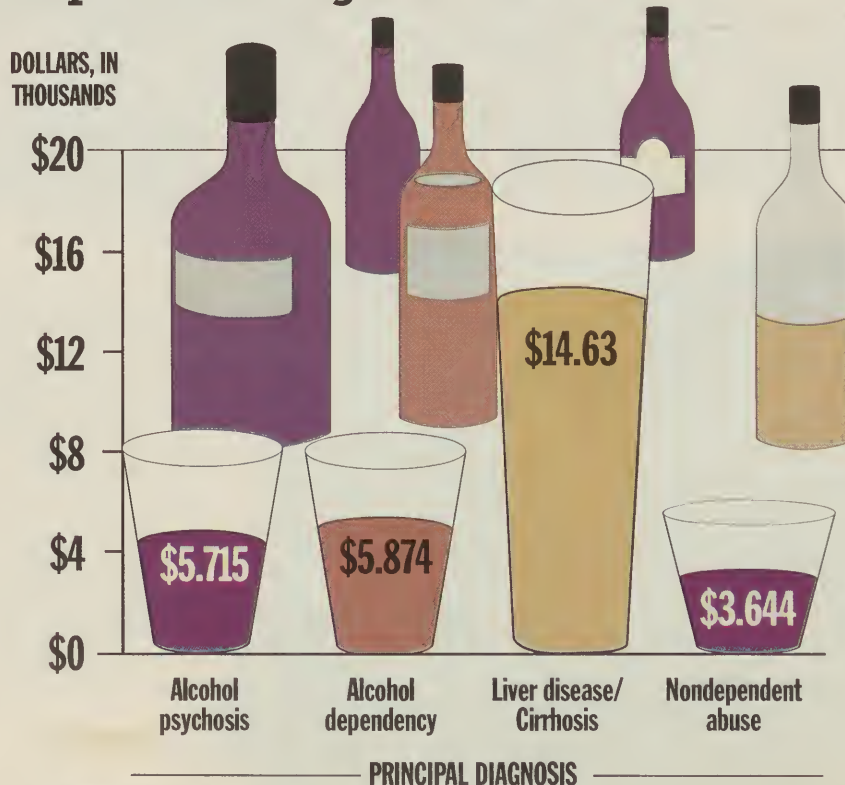
"This resolution in the words of the street is a hoax," the judge said. "I don't know whether President Phelan has the power to issue the executive order restoring elective abortions or not. That will be decided next week. I do know that this resolution has no validity." ■

## Chicago-area hospitals receive public aid grants

[ CHICAGO ] Grants from the Illinois Department of Public Aid totaling \$750,000 have been awarded to Elmhurst Memorial Hospital and Bethany Hospital in Chicago to fund counseling programs and assist public aid applicants. Elmhurst Memorial Hospital will receive a \$250,000 grant to fund a "community-based intervention program" to counsel and educate families on various health care issues, said Donald Bensing, director of the hospital's social service department. The program, which began Aug. 3, will serve the area's low-income families who have little or no medical insurance. Through the program, families will be counseled on such topics as parenting, nutrition,

## PHYSICIAN FACTS

### Alcohol-related diagnoses: Average total charges of Illinois hospital discharges in 1990



Source: Illinois Health Care Cost Containment Council

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domestic violence, drug dependency and elder abuse. The program's goal is to increase awareness of the issues and ultimately keep families out of the public aid system, said Bensing. Bethany Hospital's grant will allow the hospital to conduct medical and psychological examinations of public aid applicants to determine if clients are disabled or employable. The exams are necessary for state and federal government assistance. "They need to document their disability or inability to work before they can be considered for public aid," said Johnny C. Brown, Bethany Hospital president. "This program will help those who do not have the money to obtain the necessary medical evaluations." According to Brown, Bethany hopes to serve as many as 5,000 applicants over the program's two-year period and will accept only those clients referred by IDPA. ■

## Joint Commission releases updated hospital standards manual revisions

[ OAK BROOK TERRACE ] Continuing its 6-year-old Agenda for Change, the Joint Commission on Accreditation of Healthcare Organizations announced the 1993 revisions to its "Accreditation Manual for Hospitals" Aug. 10. The agenda's focus, which officials say will continue through the 1995 edition, places the patient at the center of hospital activities.

Instituted last year, the concept of continuous quality improvement has been expanded to include an emphasis on improved performance. Central themes in the new standards include leadership responsibilities, the function of internal systems and processes, and performance measurement.

"A hospital's performance can only be improved when its important patient care functions – and the outcomes of those functions – are systematically assessed," said Dennis S. O'Leary, M.D., JCAHO president. "Beginning with the 1993 manual, standards will increasingly require hospitals to measure, assess and improve these important functions."

"The hospital standards manual will eventually be built entirely around the patient, literally tracking him or her from admission through discharge or transfer," Dr. O'Leary added.

At its executive briefing for hospital leadership to announce the changes, the JCAHO detailed its concept of continuous quality improvement instituted in 1992 and its relationship to organizational performance; new functionally oriented standards and related scoring guidelines; evolving standards for quality assessment and improvement; performance standards for the responsibilities of medical and nonmedical staff departments; and the survey process for 1994 and beyond.

Three new chapters were added to the 1993 manual: addressing patient and family education; staff orientation, training and education; and responsibilities of department/service directors. As in the 1992 edition, these standards were collected from throughout the manual and consolidated into new chapters.

The revised standards place medical staff's monitoring and evaluation at the center of overall organization quality

assessment and improvement. Put on hold last year, these activities include surgical case review, drug usage evaluation and blood usage review. Now individual organizations will be required to determine the frequency of monitoring and evaluation rather than adhering to previously specified frequencies. ■

## Physician recruitment workshops slated

[ SPRINGFIELD ] The Illinois Department of Public Health Center for

Rural Health will present workshops focusing on physician recruitment next month. The Physician Recruitment Workshop – Sept. 9 in Rockford, Sept. 15 in Peoria and Sept. 22 in Mt. Vernon – is open to physicians, health care professionals, hospitals, county board members or anyone who foresees a recruitment problem arising in their area.

Scheduled speaker and workshop leader is Nelson Tilden, who has written two books on physician recruitment and retention, and has served as president of the Kansas Hospital Association and regional vice president of a nine-hospital rural system. He is a consultant in medi-

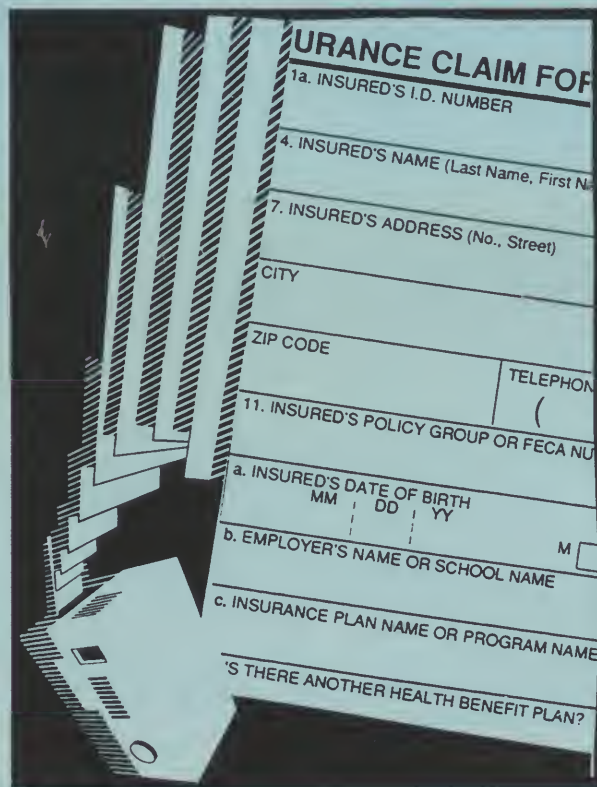
cal and health care recruitment.

The workshop will offer an overview of health care trends affecting recruitment and will include developing recruitment plans; working with a recruitment committee; creating medical staff support for recruitment; designing a compensation package; screening and interviewing; and creating a retention plan. For registration information, contact the Illinois Department of Public Health Center for Rural Health at (217) 782-1624. ■

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(8/28/92)



# STDs on the downswing in Illinois, says IDPH

**PUBLIC HEALTH:** Although syphilis is still increasing, the decrease in gonorrhea and chlamydia in 1991 has lowered levels of reportable STDs in Illinois. By Anna Brown

[ SPRINGFIELD ] Despite reports of a rampant syphilis epidemic in Cook County, levels of reportable sexually transmitted diseases in Illinois, excluding HIV, dropped 6 percent in 1991, according to figures released by the Illinois Department of Public Health. In 1990, the state reported 65,936 cases of gonorrhea, chlamydia and early syphilis combined, which dropped to 61,968 in 1991.

Gonorrhea showed the most significant decrease at 11 percent, while chlamydia dropped 4 percent. Syphilis, however, jumped from 3,598 cases in 1990 to 5,046 cases in 1991, for a 40-percent increase. The city of Chicago accounted for 83 percent of all cases of early syphilis in Illinois, an increase of 122 percent since 1980. In the rest of the state too, syphilis numbers are still soaring, with a 56-percent increase from 1990 and a 153-percent increase since 1980.

Charlie Rabins, IDPH STD expert, said the decrease in gonorrhea and chlamydia is particularly important in that those diseases, along with trichomoniasis and other STDs producing genital ulcers, help spread HIV at a faster rate. According to a National Institutes of Health study of relationships between HIV infection and other STDs, HIV not only may be transmitted more quickly in the presence of other STDs, but it may also alter the "natural history, diagnosis or response to therapy" of other STDs.

"Lesions from genital ulcers in the presence of HIV tend to be more infectious because they last longer," Rabins said. Gonorrhea is dangerous to women, Rabins said, because it may increase the risk of pelvic inflammation disorder, and chlamydia can cause sterility.

Rabins cited the difference between bacterial and viral infections as a major factor in treating STDs, but he said that unless treatment is sought, the number of STDs will continue to escalate. "People may not seek treatment if they are doing something illegal," such as trading sex for drugs, or they may not know whom to call, he said. "With syphilis, men may get lesions on their penises and think they've cut themselves. Also, rectal lesions are internal." Rabins said people tend to seek treatment for gonorrhea because of the burning discharge, but the incidence of gonorrhea is higher than that of chlamydia or syphilis possibly because of an antibiotic resistance making the disease more expensive to treat. He said in recent years more resources have been directed toward fighting congenital syphilis, which has resulted in a 40-percent to 50-percent mortality rate. "Prioritized control efforts toward syphilis may have affected resources for gonorrhea to some extent," he said.

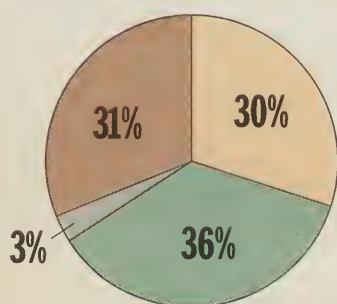
**PART OF THE REASON** there is more gonorrhea than syphilis outside of the Chicago area is that syphilis outbreaks in rural communities are much easier to control, Rabins said. Outbreaks do occur in smaller communities, he said, adding that drug problems in Kankakee, Champaign and Peoria contribute heavily to downstate transmissions.

Although rates of STD transmission have been determined to be much higher for the financially disadvantaged, the department does not collect data on the relationship between transmission and socioeconomic status, but Rabins said those who live in urban areas are more at risk.

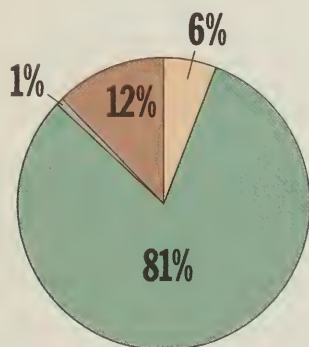
## STDs in Illinois in 1991, by race



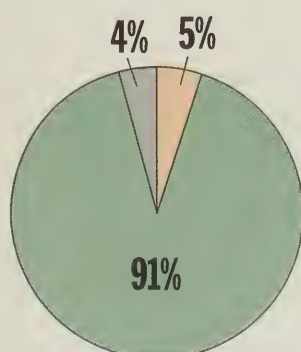
### Chlamydia



### Gonorrhea

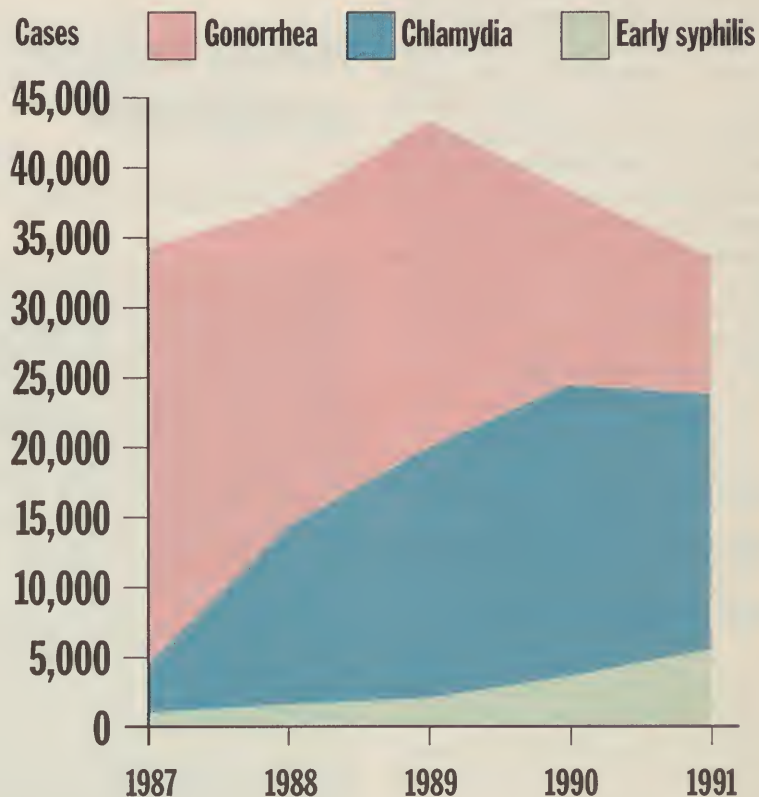


### Early Syphilis



Source: Illinois Department of Public Health

## STDs in Illinois 1987-1991



Source: Illinois Department of Public Health

IDPH has broken down STD data by race. In 1991, the department reported there were 296 cases of gonorrhea per 100,000 people in Illinois. Among the African-American population, that rate rose to 1,616. For primary and secondary syphilis, the general rate was 21, and the African-American rate was 133.

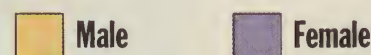
**IN GENERAL, STD RATES** in Illinois are somewhat higher than those for the rest of the country. Nationally, in 1991, 22,107 cases of primary and secondary syphilis were reported, with a rate of 17.7 per 100,000, while in Illinois, with 2,446 cases reported, the rate reached 21. The United States reported 609,459 cases of gonorrhea, with a rate of 233, compared to the Illinois rate of 296, with 33,823 cases reported. Chlamydia is not reportable in all states, but the disease is 1.5 to two times more prevalent in young women than gonorrhea is, which

is a serious problem, Rabins said.

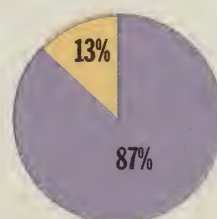
The current syphilis epidemic started in the West around 1984 and traveled to the East, Rabins said. Now it is particularly bad in the Midwest. "Most Midwest states are up compared to last year," he said. Since 1980, the number of early syphilis cases in Illinois has increased 127 percent, with a 40-percent increase from 1990. Gonorrhea rates have been steadily decreasing since 1989, when 42,744 cases were reported. It was the highest peak since 1981, when 44,794 cases were reported.

Since 1980, the number of gonorrhea cases has decreased by 28 percent. Although chlamydia numbers jumped 168 percent since 1987, in 1991 23,099 cases were reported as compared to 24,144 cases in 1990 – a 4-percent decrease.

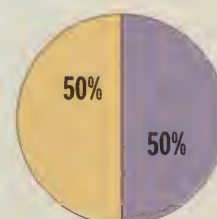
## STDs in Illinois in 1991, by sex



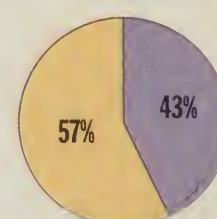
### Chlamydia



### Early Syphilis



### Gonorrhea



Source: Illinois Department of Public Health



## Budget cuts bring layoffs and a court challenge

**FISCAL WOES:** State government's belt-tightening prompts layoffs and a legal challenge to the hospital assessment program. By Kevin O'Brien

[ SPRINGFIELD ] The General Assembly's fiscal 1993 belt-tightening has resulted in predictable layoffs and a not-so-predictable court challenge. Illinois Department of Public Aid Director Phil Bradley announced Aug. 10 the elimination of 625 department jobs over the next 90 days. The largest layoff plan announced by any state agency, IDPA cuts include 406 positions in Cook County, 59 in Sangamon County and the rest in 35 other counties. The Cook County layoffs result from elimination of the transitional assistance program for able-bodied adults, which was administered in Chicago. The program for unemployable adults and families will continue.

"The layoffs fulfill the governor's commitment to operate Public Aid more efficiently," said Bradley. "We've carefully selected the positions to be eliminated so that we can maintain services for our 1.3 million clients."

The layoffs will begin immediately, but most will occur after Aug. 31. Because affected employees can apply for vacant positions in the agency, only 472 people are expected to remain unemployed. In addition to the layoffs, IDPA plans to eliminate 158 positions through attrition during the next fiscal year.

"By combining layoffs and attrition, Public Aid expects to realize a total savings of \$10.2 million this fiscal year and have its payroll down to a projected 8,995 persons by this Dec. 31," said Bradley. He said the agency payroll exceeded 10,000 employees in June 1990.

Apart from the 238 transitional assistance jobs, 105 jobs in general administration will be cut. Four of those positions are in communications, and six are in legislation and external affairs. A total of 120 other positions will be eliminated by increasing the number of cases per caseworker in local offices. The remaining positions will come from closing or consolidating regional and downstate local offices and reducing clerical support for professional staff. Bradley said that although management employees represent 23 percent of the IDPA work force, this category absorbed 30 percent of the reductions.

**MEANWHILE, A CHICAGO ATTORNEY** has filed a lawsuit challenging the new hospital assessment plan Gov. Jim Edgar signed into law July 8.

The class action suit was filed on behalf of Margaret Behr, an Alzheimer's patient and a resident of the Americana Nursing Home in Rolling Meadows. The complaint alleges that the \$6.30 per occupied bed tax on Illinois hospitals is unconstitutional because the cost of the tax can be passed on to private patients.

Under the plan, hospitals and nursing homes with relatively solid bottom lines will pay more money into the Medicaid system than they will be reimbursed. The assessment program is necessary to capture federal matching funds to help finance the state's \$4.8 billion Medicaid budget. Without it, Illinois faces a \$735 million Medicaid budget gap.

"Because providers of long-term care

are free to pass on the full cost of the tax to residents who are not exempted by enrollment in such a program, the tax becomes an unconstitutional form of discrimination based on age and health status, under which elderly and infirm citizens are being forced to subsidize health care costs for indigents," the suit says.

The suit, which names as defendants

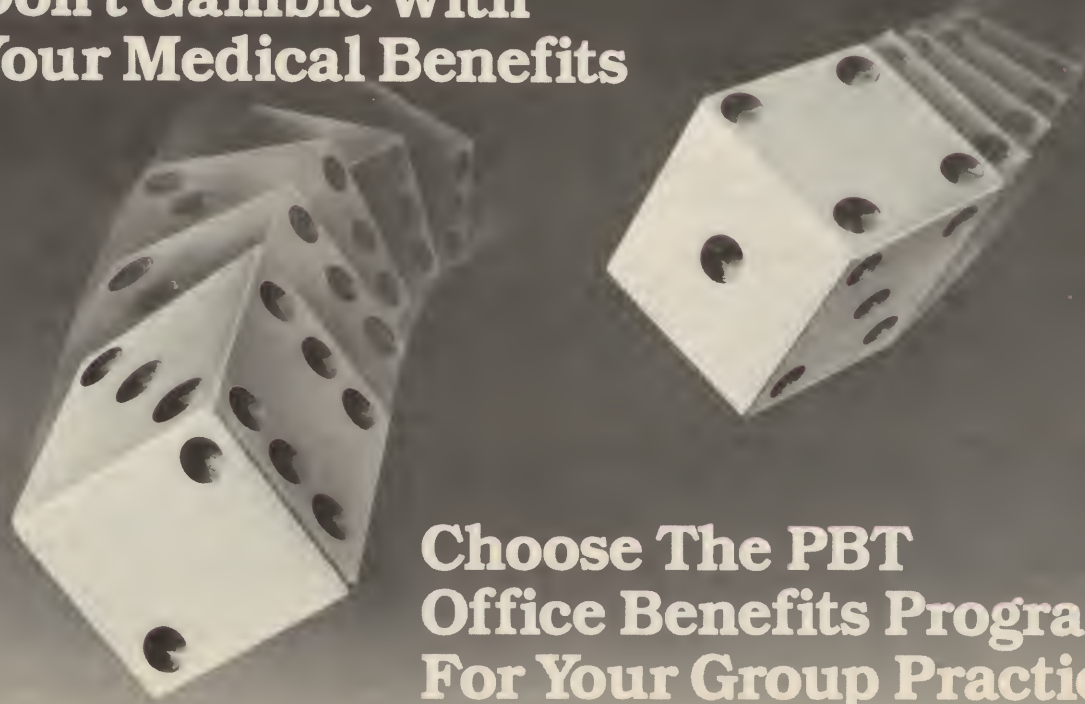
Illinois Comptroller Dawn Clark Netsch, State Treasurer Patrick Quinn and Illinois Department of Revenue Director Douglas L. Whitley, alleges the plan violates the equal protection and due process clauses of both the Illinois Constitution and the U.S. Constitution. As of press time, no hearing date had been set. ■

## As near as your phone

Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654 from 8:30 a.m. to 4:45 p.m. Monday through Friday.

In addition, ISMS President Arvind K. Goyal, M.D., is available for calls the first Wednesday of every month at extension 1333. ■

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# Illinois Medicine

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## EDITORIAL

# Summer school

Now it gets interesting.

Presidential campaigns usually move into full swing after Labor Day, allowing the candidates (and the electorate) a chance to recover from the conventions and gear up for the sprint to Election Day. It doesn't look like 1992 will follow the regular patterns, though, as one candidate takes to the road with a bus and the other takes Air Force One hopscotching across the country.

Health care promises to be a very big issue in this campaign; conventional wisdom says that health care was the issue that turned the special senatorial election in Pennsylvania on its head earlier this year, and the rhetoric on the national level has already begun.

In Illinois the campaign for the U.S. Senate has been running full tilt since the March Democratic primary. That Illinois race has received and will continue to receive national media coverage both as an item of interest in and of itself and as a forerunner of political trends in '92 and beyond.

None of which should make us forget Springfield. As happens every 10 years,

redistricting means upsetting the applecart in the General Assembly, with everyone running for everything.

You know it's going to be an interesting year when the candidates move beyond handing out fliers at the train and subway stations and start going door-to-door asking for votes – in August.

You need to ask the right questions and you need to know the candidates. That's why *Illinois Medicine* will dedicate itself to helping the physicians of Illinois become educated voters over the next two months. We'll feature analyses of various health care reform proposals –

good for sharing with your patients and with community leaders in your hometown – and we'll look at the closest and most hotly contested races in the state.

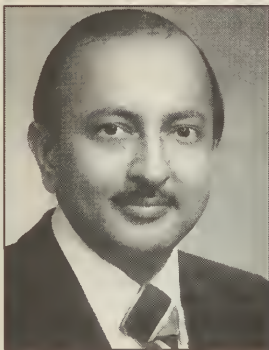
Expanded election coverage is something the Society's strategic plan included in *Illinois Medicine's* goals – but it won't do candidates or voters any good unless you take advantage of it. Consider the information sort of summer school for Illinois voters – and do your homework!

*Redistricting means upsetting the applecart in the General Assembly, with everyone running for everything.*

## PRESIDENT'S LETTER

# If better is possible, good is not enough: Interim report from your president

By Arvind K. Goyal, M.D.



*"I am using this column to provide you with an ongoing, timely report of the president's tour of duty."*

David, a second grader, was bumped while getting on the school bus and suffered a cut on his cheek. At recess he collided with another kid and two of his teeth were knocked loose. And after school, while sliding on ice, he fell and broke his wrist. At the hospital, his father noticed David was clutching a quarter in his good hand. "I found it on the ground when I fell," David said. "This is the first quarter I ever found. This sure is my lucky day."

Working for you, the past four months, I haven't found that first quarter yet. But I haven't missed it either.

Many of your delegates and alternates in the House were generous in their support and suggestions, when you elected me your president this past April. The 100 or so suggestion cards returned were very educational, however, no CME credits were allowed! I got a better feel for problems faced and perceived by our profession around the state. The expressed desire for more aggressive and unified legislative and public education strategy was overwhelming. And one response absolutely humbled me: "Good luck, you seem to need it!" I had asked for guidance, that I got.

The sometimes embarrassing recognition and roasting that comes with the job started a few minutes after that House meeting adjourned. One of your past presidents, a friend until that day, publicly presented a hand-painted stone with a drawing of my famous shoes on it! And the first press call also came in the same afternoon. As your president I was expected to explain the whats and whys of everything spoken in Oak Brook over those three days of meetings!

I have enjoyed most of what I had to do! The direction from Dr. Jere Freidheim, your past president and current board chairman, the support from Mr. Alexander Lerner, your executive vice president, and all of his staff, have helped keep me going. I am taking the somewhat unusual step of using the president's column to provide you with an ongoing, timely report of the president's tour of duty and actions of your society on your behalf. It has never been done before. I thought, I'll risk using this column because you need to stay informed. And your society deserves your input.

The county medical society tours started early this year. At Knox, Coles-Cumberland and Williamson County meetings, I learned more than I gave. I was able to speak longer and louder after a customized Indian ethnic meal prepared by talented members and their spouses in Charleston. In Will-Grundy County I enjoyed participating with colleagues seeing patients at the pride of that community, their free clinic. That is something I plan to do more during the balance of this year.

In a new initiative undertaken this year, I was invited to represent you before

the executive committees and governing councils of five specialty societies, thus identifying common agendas and concerns and opportunities to work together for a unified medical profession in Illinois, in the months and years to come. And similarly, appearances before three large hospital medical staff quarterly meetings and a hospital auxiliary have provided new perspectives and yet another way to reach out. More of such meetings are yet to come. The two universal health care bills in Springfield this summer intensified my appearances on your behalf. My testimony before joint health subcommittee hearings of the House and Senate, a press conference in Springfield, and meetings with several editorial boards in Chicago, Springfield, and suburbs left me with little time to get in trouble.

And then the usual: Attendance at annual meetings of adjoining state medical societies, professional ethnic groups, three church groups, and eight business and health care discussion groups have kept it interesting. Your society's messages on health care reform, RBRVS, malpractice tort reform, tuberculosis, tattoo parlors, other public health issues, self-referral legislation, and provision of free medical care by volunteering and caring physicians have consistently gotten across through such forums and proactive editorials written for major newspapers as well as several newspaper, television and radio interviews. Other opportunities are being explored and sought.

On a personal note, you have allowed me to attend all the board and executive committee meetings at ISMS and those with outside organizations, several ISMS council and committee meetings and still meet my obligations at my county medical society, my branch, my two hospitals, medical licensing board, the American Medical Association Annual Meeting, the unified societies advisory committee meeting at the AMA, and the IMG advisory committee of the AMA, the American Cancer Society meetings, Task Force on Acute Care, and the like. And in my spare time, with your blessings, I have been able to maintain my solo family practice and my family. That one week vacation really helped.

As the year moves on, my excitement seems to grow! It's been fun working for you thus far – some work and some play. Thanks to you for this opportunity and privilege to serve you.

Your input by letter or phone calls is always welcome, especially when you feel your society can do better! You can call anytime but barring an emergency, I will continue to be personally and immediately available for your calls at 1-800-782-ISMS, Ext. 1333, from 11:00 a.m. to 12:00 Noon, the first Wednesday of each month. The next date coming up is September 2, 1992.





*"Don't think of me as your patient. Think of me as part of your continuing medical education."*

## GUEST EDITORIAL

# Protecting your license

After physicians receive a DEA number and full state licensure, many expect that any future contact with licensure authorities will be limited to renewal payments. But mandatory filing of reports regarding professional conduct and ability to practice – required of health care institutions, professional associations, professional liability insurers, state's attorneys and state agencies – increases the likelihood that at some time physicians will have more than casual contact with the state licensure authority.

The Illinois Department of Professional Regulation investigates allegations concerning professional conduct or ability to practice. Because a department inquiry may result in licensure sanctions, which may affect medical staff privileges and insurability, and because sanctions can be reported to the National Practitioner Data Bank, physicians who are contacted by department representatives should be knowledgeable about the inquiry and review process.

When a report has been filed by a health care institution, professional association, professional liability insurer, state's attorney or state agency, IDPR officially notifies the physician, providing a copy of the report and inviting a response. After 30 days, the Medical Disciplinary Board reviews the report, regardless of whether or not the physician has responded. The response is the physician's earliest and best opportunity to remove a case from the department's docket. By answering honestly and addressing specific points that could lead to sanctions, the physician may resolve any questions the department might have, negating the need for a more detailed department investigation. On the basis of the mandatory report, supporting documentation and the physician's response, the board decides to close the file or refer it for investigation.

In an investigation, the board assigns

the case to a medical investigator who collects records; interviews potential witnesses, including the patient; and may ask the physician for a statement regarding the alleged violation of the Medical Practice Act. One or more "informal" or "disciplinary" conferences may also be scheduled at the IDPR offices in Chicago or Springfield; these may be attended by investigators, department attorneys, members of the Medical Disciplinary Board and physicians employed by the department to review cases.



**Edward F. Bruno** has served as counsel and chief hearing officer to the Illinois Medical Disciplinary Board. He is in private practice with the Chicago law firm of Bruno & Weiner.

A physician called to attend a conference may bring his or her lawyer. Conferences often result in the department's offer to settle matters on agreed terms. No matter how the department labels the meeting, however, sanctions resulting from such agreements are not "informal." If the case cannot be settled, IDPR may file a formal charge, initiating a formal hearing process before the Medical Disciplinary Board. Such a hearing resembles a civil trial, and virtually all physicians who enter the process are represented by counsel.

In fact, at every stage of the process – beginning with the first correspondence from the department and including every contact with department representatives – the physician has a right to be represented by an attorney. This applies even to an investigator's unannounced visits to the doctor's office and especially to "informal" meetings that may result in disciplinary action.

The Medical Practice Act of 1987 contains many safeguards to protect physicians and their patients from unreasonable intrusion into the physician-patient relationship. Those safeguards are an implicit recognition of the essential privacy involved in such a relationship. Physicians who take advantage of every safeguard are merely acting prudently, because much is at stake for their professional health and their patients' trust and well-being.

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## GUEST EDITORIAL

# Will the real patient advocate please stand up?

Several months ago, I welcomed a new patient to my practice. As she signed in I glanced at her insurance card; she was covered by one of the large insurance corporations we deal with daily, with a name like Worldwide Amalgamated Incorporated Mutual Benefit Trust, or something close to that.

On the back of her card was the warning: "A WAIMBT patient advocate must be contacted prior to any elective admission or surgery."

I went about my business with the patient, but as we wrapped up our session I asked her if she knew what was meant by that statement on her card.

"Oh, they have people there who look out for the patients and make sure the doctor doesn't do any unnecessary surgery or anything," was her unhesitating response.

I smiled, thanked her for the explanation and wished her well. But the significance of the wording of the statement on that card and the woman's acceptance of it at face value, continue to disturb me.

"Patient Advocate." Sure enough, the phrase evokes visions of a kindly benefactor tirelessly translating confusing medical jargon for patients, offering unbiased opinion and counseling, and diligently protecting unwary patients from diabolical surgeons eager to remove their healthy gallbladders for huge profit. Sort of a Glenda the Good Witch in the unfamiliar, Oz-like land of high-tech modern medicine.

But by supplying a "patient advocate," one implies the presence of something (or someone) from which patients need protection, whether they realize it or not. The source of this supposed peril is, of course, the medical system – in particular, the doctor.

At the time, I was loath to shatter my patient's illusions about her "patient advocate" by explaining that in fact it was likely to be a low-paid employee with minimal medical training (perhaps none, beyond medical terminology), using a simplistic cookbook approach to complex medical decision making, and whose goal, far from guiding the patient to the best possible health care, was to dole out whatever care would cost the corporation the least amount of dollars.

Now, however, I regret having lost the opportunity to present a more accurate picture for that patient.

As the debates over the present and future state of the nation's health care system rage on around us, sometimes it seems the only voices drowned out in the angry cacophony are the patient's and the doctor's. Physicians are increasingly assailed as part of the problem, not part of the solution. We grumble about this in doctors' lounges and locker rooms; we send representatives to argue our case before Congress; and our journals

are filled with letters and editorials expressing our outrage.

Yet how many of us have dared – or bothered – to take our case directly to the objects of all this uproar over health care: our patients? The profile of the great health care debate that reaches them through the media, government and third party payers is too often biased, sensationalized, incomplete or inaccurate. If we continue to rely on *USA Today* and *People* magazine to define us and the climate we work in, we deserve all the disdain we get. Yet we paternalistically avoid discussing our administrative headaches with our patients – do we think they're too simple-minded to understand it, or do we think they just don't care?

How many of your Medicare patients can define "DRG" or know what the RBRVS was all about? Ask and you'll find two things that may surprise you: 1. Despite all the cries for health care reform we hear today, the public is sadly uninformed about what makes our health care system tick; and 2. people are more than eager to discuss these topics with their doctor, usually showing a sympathetic frame of mind. Patients deal with government bureaucracy and legal red tape every day, and given a chance, they're more than willing to sympathize when their doctor describes how such factors affect their health access and costs.

The importance of having such discussions with one's patients goes far beyond mere "good PR" for the profession. Patients need to know all the factors that are intertwined in medical decision making in 1992, including the financial, regulatory and medico-legal pressures that affect us and, in turn, them and their health.

Although all physicians can initiate these discussions in their offices and exam rooms, other forums are available and should be used. Neighborhood seniors' centers welcome the chance to have a physician come and give a talk – in my experience, no matter what the topic, as in real life it's nearly impossible to talk medicine without talking law, government, and cost.

If you can't find the right audience to

express your views, the Illinois State Medical Society's "Partners for Health" program matches volunteer speakers with a variety of groups for discussions on health related topics, to further the goal of having patients take a more active part in their health care management. The reception is always warm; it takes only an hour of your time; and it's an opportunity to demonstrate our solidarity with patients on health care issues that affect all of us.



**Sheilendr Khipple, M.D.**, an internist from Mt. Prospect, is an active member of the ISMS "Partners for Health" speaker's bureau.



# "ISMIE's Risk Management Seminar On Cancer Was A Lifesaver ...Literally."

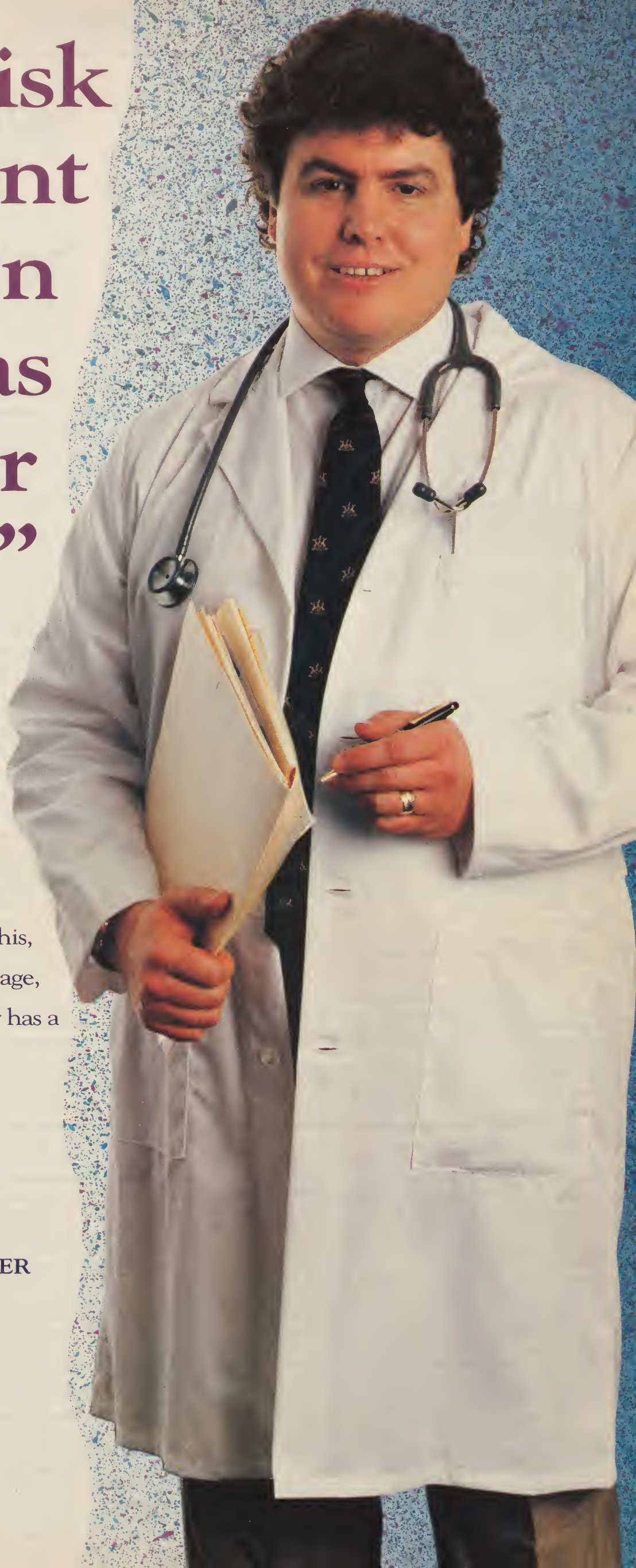
"I had just attended an ISMIE risk management seminar that dealt with the symptoms of cancer most commonly overlooked or misdiagnosed. Information presented at the seminar prompted me to ask questions that did not pertain to the patient's presenting complaint. Because of this, I was able to detect the cancer in an early stage, surgery was performed, and the patient now has a very good prognosis."

- John V. McInerney, D.O.

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Exchange  
Q & A

PAGE 11

# ISMIE Update

Take action  
on incidents  
to reduce  
liability

PAGE 10

## Case in Point

*A regular feature using hypothetical case histories to illustrate loss prevention maxims.*

By Carol Brierly Golin

### Case #1

**Presenting complaint and initial diagnosis** – A 62-year-old man with a six-year history of abdominal pain, vomiting and nausea was referred by his family physician to a general surgeon because the symptoms were worsening. The physician suspected gallbladder disease.

**The case in brief** – The surgeon discussed treatment options, and the patient elected to undergo a laparoscopic cholecystectomy. During surgery, the gallbladder ruptured, and multiple small stones and bile spilled into the abdomen. The debris was removed, and the patient was discharged the day after surgery. Over the next two weeks, the patient began developing abdominal discomfort, fever and difficulty eating. A month after surgery the patient was rehospitalized for GI bleeding and bleeding from the rectum. A sonogram revealed dilation of the common bile duct and presence of gallstones. Emergency surgery was performed, which revealed gallstones in the common bile duct, severe pancreatitis, mesenteric venous insufficiency and gangrene of the bowel. The stones were removed from the common bile duct, a substantial segment of the small bowel was resected, and the patient was treated aggressively for pancreatitis.

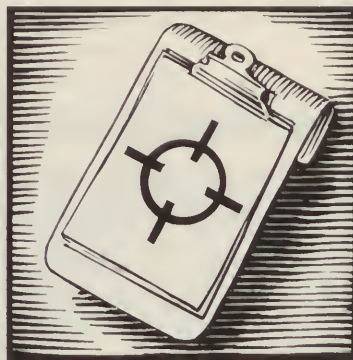
**The resulting claim** – The patient's attorney filed notice that the patient intended to sue for negligence, alleging failure to recognize and correct the problems present at surgery, failure to perform intraoperative cholangiography, failure to diagnose stones in the common bile duct, and failure to diagnose and promptly treat subsequent acute pancreatitis.

**The outcome of the claim** – Because the patient had stones in the common bile duct not found at surgery, the case was indefensible. A videotape made during the surgery documented some of the suit's allegations. The case was settled for \$180,000.

### Case #2

**Presenting case and initial diagnosis** – A 45-year-old woman with increasing symptoms of gallbladder disease elected to have a laparoscopic cholecystectomy.

**The case in brief** – During the laparoscopic procedure, the surgeon unknowingly punctured the abdominal aorta several times with a trocar. He did not discover the hemorrhage, and the patient died.



**The resulting claim** – The family sued the surgeon and the assistant surgeon for wrongful death, and failure to recognize and aggressively treat injuries. The complaint also alleged that neither physician was properly trained and credentialed in laparoscopy.

**The outcome of the claim** – During deposition the surgeon admitted that this was the first time he had performed a laparoscopy. The assistant surgeon had only didactic training in the procedure. The case was settled for \$750,000.

### Case #3

**Presenting complaint and initial diagnosis** – A 50-year-old

man with long-standing symptoms of gallbladder disease opted to have a laparoscopic cholecystectomy.

**The case in brief** – The gallbladder was removed, and the patient was released the day after surgery. Seven days later, the patient was readmitted to the hospital with severe abdominal pain. A second surgery was necessary to repair a common bile duct injury.

**The resulting claim** – The patient sued for negligence, delay in recognizing and correcting injury, pain and suffering, and failure to obtain informed consent. He alleged that if he had fully understood the possible risks and complications of a laparoscopic cholecystectomy, he would have selected an open procedure.

**The outcome of the claim** – The case was settled for an undisclosed amount.

**The points these cases make** – Malpractice claims arising from laparoscopic cholecystectomies are developing, said

Richard Prinz, M.D., a professor of surgery at Loyola University Medical Center in Maywood. The number of claims is not large yet but points to areas of potential liability.

"In the first case, rupturing the patient's gallbladder as it was being removed is not malpractice," said Dr. Prinz. "It happens in anywhere from 10 percent to 25 percent of laparoscopic procedures. When it does, the surgeon should irrigate and suction the operative area to remove as many stones as possible."

He suggested that the real problem was the surgeon's failure to find and remove the stones in the common bile duct – a problem that could have been avoided if intraoperative cholangiography had been ordered. The second problem was that the surgeon was slow to recognize the developing pancreatitis and associated complications. An amylase test for pancreatitis should have been ordered as soon as the patient complained of problems.

Trocar injuries, like those described in the second case, can be eliminated with "use of appropriate surgical techniques, proper positioning of the patient, and checks along the way to assure proper insertion of the trocars," Dr. Prinz said.

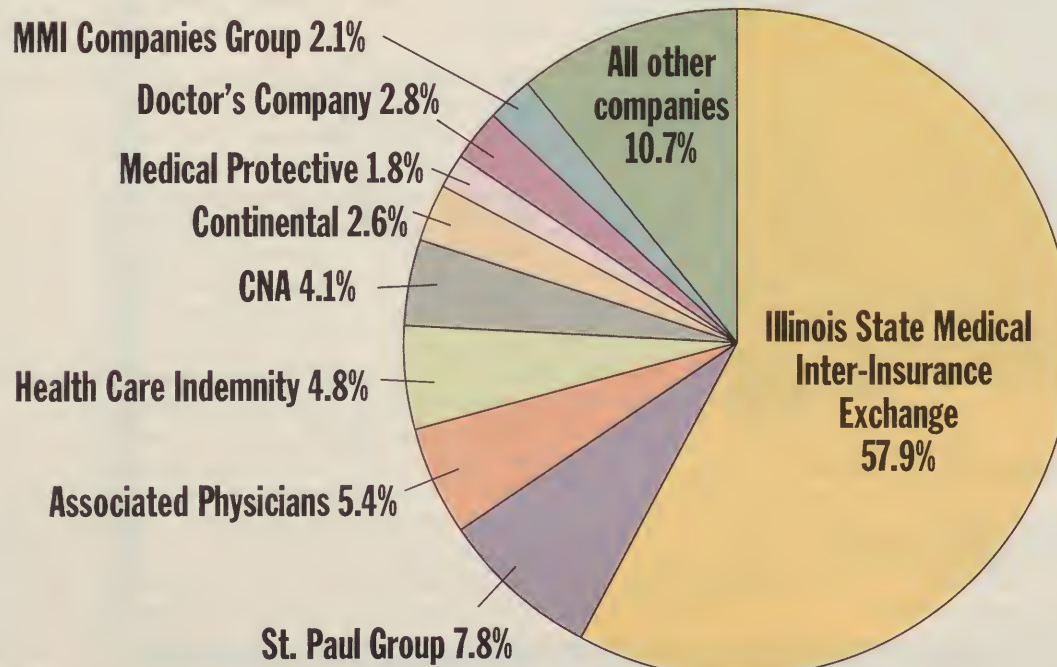
The third case illustrates the most frequent major problem seen with laparoscopic cholecystectomy – injury to the common bile duct. "This is probably one of the most devastating problems and the one that will account for the majority of claims," he said. "With the laparoscopic technique, the surgeon is working in two dimensions, not the traditional three dimensions with which he or she is most familiar. Tactile sensation is missing, so it can be easy to misinterpret or fail to recognize some of the anatomy. Routine cholangiography during the procedure can prevent such misidentifications."

To help avoid liability associated with the laparoscopic cholecystectomy, Dr. Prinz offered these pointers:

- Obtain proper training and credentialing before attempting

(Continued on page 11)

## Top medical malpractice insurers in Illinois by market share\*



\*Based on direct premiums; includes hospitals.

Source: A.M. Best Company; Bestlink Database as of 12/31/91.



# Take action on incidents to reduce liability

**RISK MANAGEMENT:** After an incident occurs, physicians should follow steps prescribed by the Exchange. By Tony Sullivan

[ CHICAGO ] When an "incident" occurs during a medical treatment or procedure, few responses can be as potentially damaging to a physician as doing nothing, say medical and legal risk management experts. Incidents are the seeds of malpractice lawsuits, and leaving them unreported to your malpractice insurer can expose you to a substantially weakened and costly defense if a lawsuit

is filed later, they say.

An incident is a situation that may prompt a malpractice claim or lawsuit for any of a variety of medical or non-medical reasons, explained Fred Z. White, M.D., a member of the Risk Management Committee of the Illinois State Medical Inter-Insurance Exchange and a former chairman of the Exchange. It can range from an intangible "gut feel-

ing" that a patient is unhappy with your care to an obvious adverse event, such as a drug interaction or surgical intervention that resulted in patient injury.

Incidents differ from claims and lawsuits in that they involve no actual threat or notice of litigation. But they parallel claims and lawsuits in the attention they deserve, Dr. White said. Like claims and legal actions, incidents should be reported to the Exchange as quickly as possible to allow the Exchange's claims analysts to investigate the situation and gather information while it's still memorable. The claims analysts will talk only to the physician involved, not to the patient.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

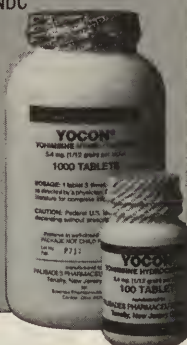
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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*"The ostrich approach  
can be very dangerous  
and can increase the  
likelihood of a lawsuit."*

**ATTORNEY DAVID HALL**

"The Exchange wants to know when an incident occurs so that we can do the necessary investigation and planning," said Dr. White, a family physician in Peoria. "It's important to get the data from physicians involved in an incident while it's still fresh in their minds."

Even though prompt reporting of incidents offers clear benefits to both the physician and the Exchange, certain obstacles sometimes prevent a physician from filing a prompt report. Many physicians fear that reporting an incident will increase their premium rates. That's not the case with the Exchange, Dr. White said.

"Doctors should be assured that reporting an incident to the Exchange will not put a stain on their records," he stressed. "The Exchange's incident reporting policy is designed to protect physicians, not harm them." In addition, an incident can provide an opportunity for physicians to communicate with patients.

**SOME PHYSICIANS FEAR** their peers will hear about the incident and question their medical skills. But that fear is also unfounded, according to David Hall, a malpractice defense attorney with Lord, Bissell & Brook, Chicago. "Physicians may not know to what extent [a reported incident] is privileged information," he said. "Many physicians don't want their peers to know they've been involved in an incident of some sort, and they're willing to take a chance that they won't run into trouble down the road by not reporting it." But that tactic can be risky. "The ostrich approach can be very dangerous and can increase the likelihood of a lawsuit," Hall said.

Physicians also may be unaware that they're required to report certain incidents as a condition of insurability, or they simply may not know how to report incidents, said Tim Nickels, a malpractice defense attorney with Wildman, Harrold, Allen & Dixon. Malprac-

tice insurers typically spell out this information in their insurance policies. "Physicians should review their insurance policy annually and be familiar with what it says about the necessity of reporting certain incidents and what procedure to follow." Some policies require physicians to report certain incidents, while others only recommend reporting them.

The Exchange, for example, urges insureds to report the following incidents:

- Death under unusual circumstances or if the family is upset
- Loss of a major body part
- Permanent or partial impairment of a bodily function
- Loss or impairment of any of the five senses
- Severe disfigurement or paralysis
- Complaints about the amount of a medical bill
- Any rumor or indication of a problem from any source
- Any complication of treatment, even if anticipated
- Any injury under unusual circumstances

Physicians also should pay particular attention to informing the Exchange about "informed refusals," said Dr. White. These involve situations in which patients refuse a physician-recommended treatment or procedure after the physician properly explains what is involved and the inherent benefits and risks. The Exchange's records show that informed refusals and the incidents previously listed can develop into a claim or lawsuit.

The Exchange has established a simple protocol for reporting incidents, according to Dr. White. Physicians should first fully document the details about the incident in the patient's medical record immediately after it occurs. Then, as soon as possible, they should call the Exchange's policyholder relations department at (312) 782-2749, ext. 3510, to report the incident. They should have available their policy num-

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**FRED Z. WHITE, M.D.**

ber, the patient's medical record and any correspondence associated with the incident. "A claims analyst from the Exchange will speak with the physician and other care givers involved in the incident to gather information on what occurred while it's still fresh in their minds," Dr. White said.

(Continued on page 18)



## Case in Point

(Continued from page 9)

the procedure. "Training should be both didactic and practical. Many courses offer training on animals. Then there must be a bridge period in which a surgeon is proctored by a surgeon experienced in the LC technique. Various credentialing programs are available. Since liability extends to assistant surgeons, they, too, should have proper training and credentialing.

- Select only appropriate candidates. "It is not for every patient, and it must be applied and used wisely," warned Dr. Prinz. Patients with an inflamed gallbladder, with a large amount of fluid around the gallbladder, or with scarring

at the operative site from other surgeries should receive the traditional open procedure. Patients with possible abnormalities of the cystic duct also may be better served with an open procedure.

- Inform patients fully of known risks and complications, and advise each regarding the options available. Patients should be aware that the procedure may have to be converted to an open operation.

- Use appropriate techniques and guidelines for inserting needles and trocars to prevent internal injuries. Position patients properly and check to ensure that bleeding or other problems are not developing.

- Use intraoperative cholangiography liberally, especially if there are questions about the anatomy of the cystic duct and common bile duct.

- Be prepared to convert immediately to an open procedure. "Never proceed if you cannot define the anatomy," stressed Dr. Prinz. "Consider it a sound surgical judgment to convert, when appropriate. If there is a problem developing, the best time to deal with it is during the initial surgery."

- Advise patients to report any postoperative problems, such as abdominal discomfort, difficulty eating, bleeding or severe pain. Follow up aggressively.

"I am enthusiastic about this proce-

dures. It does a tremendous amount of good. Recovery time is much shorter, hospitalization is greatly reduced and patients can return to work faster. Patients want it, so surgeons must learn to do it with a minimum of complications," said Dr. Prinz.

Dr. Prinz noted there are two time frames in which injuries are most likely to occur. The first is in the "learning curve period," which includes the first 10 or 15 cases a surgeon handles. The second is later, when the surgeon becomes more facile, develops confidence, and considers the procedure routine. "Every patient is different, and no surgery is routine," he pointed out. ■

## EXCHANGE Q & A

**Q: What is a corporate registered agent, and why should the agent be located where I practice?**

**A:** A corporate registered agent is the attorney or member of the corporation designated to handle the corporation's business affairs. To avoid claims or suits being filed in more than one county, registered agents should be located in the same county as the physician's practice or residence. The only exceptions are physicians who practice in Cook County and whose agents are in DuPage County, or those who practice in Cook or Lake counties whose agents are in McHenry County.

**Q: What should I do when I am served a summons?**

**A:** Any papers served by an officer of the court naming you as a defendant, co-defendant or respondent in discovery must be reported immediately to the Exchange. Do not communicate or respond to the patient or his or her lawyer. Do not discuss the case with anyone.

Contact the claims department for instructions on what information should be sent with the summons and complaint to the Exchange.

You must meet deadlines for filing an appearance to the summons and complaint to avoid a default judgment against you. Failure to respond is considered by the legal system to be agreement with the allegations.

The sooner the Exchange is aware of the summons and complaint, the sooner legal counsel can be assigned and the response can be completed on your behalf. Your office staff should also be aware of the importance of the summons and complaint, and the procedure for reporting to the Exchange. A summons and complaint should be handled immediately. ■



  
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REPORT FROM AMSTERDAM

# Illinois HIV cases follow worldwide trend

*Infection increases in men and women of color, and women in general*

BY KAREN SANDRICK

**I**llinois physicians who attended the Eighth International Conference on AIDS in Amsterdam, July 19-25, have brought back little positive news about medical efforts to check the epidemic. As the physicians reported, the nearly 5,000 research papers presented at the conference paint a bleak picture: HIV infection is increasing rapidly throughout the world, especially among women and men of color, and a treatment breakthrough is nowhere in sight.

The AIDS conference demonstrated that HIV infection is now a heterosexual disease that knows no boundaries. It is rampant in Africa, affecting 7.5 million men and women, and has erupted in Southeast Asia, infecting more than 1 million people in the last five years.

"In Illinois, just as is true worldwide, people of color are proportionately more affected by HIV infection. Almost 98 percent of the cases of HIV infection occur in Cook County, [and] more than half of the individuals who are being newly diagnosed with the disease are black or Latino. Certainly blacks and Latinos do not make up half the population of the county," observed Robert McDonald, M.D., outgoing director of Howard Brown Memorial Clinic, an AIDS counseling and treatment center in Chicago. HIV infection has increased most dramatically among women in the past two years, experts note. In 1990 women constituted only 25 percent of the total number of HIV-infected adults worldwide. Currently, they compose 40 percent of the HIV population. By the year 2000, most of the newly infected will be women, predicts the World Health Organization.

"People [at the conference] clearly realized that women are a significant segment of the HIV population," said Rebecca M. Wurtz, M.D., an epidemiolo-

gist at Cook County Hospital and infectious disease specialist with the hospital's Women and Children with AIDS project. However, she lamented, "I didn't get much information [during the conference] about new ideas and new approaches to deal with this segment of the population.

"It's also frustrating that the number of HIV cases continues to rise among women [because] preventive programs in Chicago and other parts of the world haven't been successful," she added. According to Dr. Wurtz, women represent the fastest-growing segment of the HIV population in Illinois. Although women

**I**t's also frustrating that the number of HIV cases continues to rise among women [because] preventive programs in Chicago and other parts of the world haven't been successful."

— Rebecca M. Wurtz, M.D.



TERRY VITACCO



## REPORT FROM AMSTERDAM

TERRY VITACCO



**P**eople of color are proportionately more affected by HIV infection. More than half of the individuals who are being newly

diagnosed with the disease are black or Latino. Certainly blacks and Latinos do not make up half the population of the county."

— Robert McDonald, M.D.

accounted for only 4 percent of the AIDS cases diagnosed in the city of Chicago in 1984, they represented 11 percent of the AIDS cases in 1991, reported the Chicago Department of Health.

Contrary to previous scientific studies that found women with HIV experienced more symptoms and died more quickly than men, four large-scale investigations in the United States showed no differences in disease presentation or death rate between the sexes. A clinical study of more than 4,000 HIV-positive men and women in Cook County by Renslow Sherer, M.D., director of the Cook County HIV Primary Care Center, demonstrated that the death rates and the incidence of illnesses, such as *pneumocystis pneumoniae*, candidiasis of the mouth and esophagus, shingles, cytomegalovirus and TB-like infections, were similar in both sexes.

A COMPREHENSIVE REPORT by the Global AIDS Policy Coalition noted that HIV-related research and preventive efforts did not adequately involve women. For example, at a summary meeting sponsored by the Physicians Association for AIDS Care the day after the AIDS conference, Dr. Wurtz documented the lack of information concerning pelvic inflammatory disease (PID) and HIV infection.

"PID and HIV tend to occur in some of the same populations, and women who are at risk for HIV infection also are at risk for PID. However, worldwide, only three papers have been published on the intersection of the two diseases," she said.

The Women and Children with AIDS project, established at Cook County Hospital by Mardge Cohen, M.D., five years ago, makes use of the services of seven physicians, several psychologists, a nutritionist, social workers, and substance abuse counselors to provide comprehensive care to HIV-positive women and their children.

In addition to a weekly clinic, the project provides preventive counseling. "We spend a lot of time talking to high school students, young adults in church settings and in social, fun settings, to try to approach young women who might be at risk for HIV and to use creative ways of presenting the message to them. But we share some of the problems Third World countries have: We don't have effective ways to reach young people and impress

them with the message of prevention," said Dr. Wurtz.

THE NEED FOR PREVENTION is becoming more urgent as AIDS conference researchers offer little hope for a cure in the foreseeable future. Major efforts have been directed at developing a vaccine to protect against the disease. Scientists nevertheless are not optimistic, largely because of the ability of the virus to mutate.

Use of a treatment vaccine to bolster the immune system of individuals already infected with HIV has achieved some success in a handful of patients in one study. "However," said Dr. McDonald, "it is going to take a while to see the effect of these vaccines and determine whether they retain their effect over time. It would be late in this decade before we could hope to have a useful treatment vaccine.

"Anti-viral medications that have modes of action differing from those of zidovudine and didanosine are more promising than any of the vaccine efforts," said Dr. McDonald. However, added Dr. Wurtz, these drugs "are not new or innovative or exciting; so there aren't likely to be any breakthroughs."

Drug therapy is also extremely costly. The U.S. Public Health Service's Agency for Health Care Policy Research told AIDS conference participants that the annual cost of treating an AIDS patient in this country averages \$38,000, and the cost of caring for an HIV-infected individual who has not yet developed AIDS averages \$10,000 per year. "I can cite dozens of patients who spend that much on one hospitalization," added Dr. McDonald.

Although a great deal of information was presented at the conference, few issues were resolved. Said Dr. Wurtz: "My feeling about the conference overall is that there are many unanswered questions, such as: How do we create effective preventive programs for the developed and the developing world? How do we treat people effectively when the only medications we have are toxic and expensive and only moderately successful?" ■

## New AIDS cases in Chicago

Year	White	Black	Hispanic
1984	66%	26%	8%
1985	62%	29%	9%
1986	53%	35%	12%
1987	52%	35%	13%
1988	50%	36%	14%
1989	46%	40%	14%
1990	41%	44%	15%
1991	41%	46%	13%
1992	35%	50%	15%

Source: Chicago Department of Health



# Wilensky: Bush health plan features tax credits

**REFORM:** Gail R. Wilensky, Ph.D., outlines President Bush's policies on health care and tort reform. By Anna Brown

[ ST. CHARLES ] After delivering the luncheon address at U.S. Rep. J. Dennis Hastert's (R-Batavia) Conference on Health Care, Gail R. Wilensky, Ph.D., deputy assistant to the president for policy development and former head of the U.S. Health Care Financing Administration, spoke on the highlights of the president's agenda for health care and tort reform.

"Do you use government to do everything for everyone, or do you try to use government in a more focused and targeted way?" Dr. Wilensky asked. Under Bush's health care reform plan, all poor people would get full credit for their health care, she said. Lower and middle classes would receive new tax deductions, and all self-employed taxpayers could fully deduct health insurance.

The Bush plan would also virtually eliminate exclusion from insurance plans for past illnesses, she said. "For the middle class, that may be the single biggest worry right now. If you have ever had an illness, you may not be able to get

insurance for that illness for six months, a year or perhaps forever. A part of the legislation that is already on [Capitol] Hill says you get one shot at being excluded, for one limited period."

Dr. Wilensky explained that those seeking employment for the first time could be excluded from insurance coverage for six months if they had had an illness in the previous three months but that no exclusion would occur after the initial period if insurance coverage was continuous. "Knowing that if you change jobs you can continue to have insurance is a really critical element to the middle class," she said.

The final element of the Bush plan is the attack on cost drivers, Dr. Wilensky said. The plan would encourage small businesses to band together to "use their market force, get good prices and escape from some of the mandated minimum benefits the states have put up." It would also include eliminating managed care laws, reforming the malpractice system and using more electronic billing.



**Gail Wilensky, Ph.D., deputy assistant to the president for policy development, delivered the luncheon address at the 1992 Illinois Conference on Health Care.**

Under such a plan there would be "no business as usual," Dr. Wilensky said. "If you are going to change the dynamics that are causing all the spending, you have got to look at the conditions that are causing the problems."

**DR. WILENSKY LISTED** medical malpractice suits as one of the cost drivers that lead to more health care spending. "Right now people get sued for not doing as much as someone else might have done in the same situation," she said. "We would like to discourage these disputes

from the court system whenever possible."

A way of doing this would be to pass legislation mandating alternative dispute resolution, she said, explaining that some states already have such a system in place. "We're not telling states how to do it," she said. "We're saying that states have to do it."

The plan also calls for "modified English rule," she said. Under English rule, the loser in a suit pays court costs. With modified English rule, if the plaintiff rejects a settlement and the judgment approximates the amount of the offered settlement, the plaintiff must pay the court costs. "Modified English rule says you can go to court, but you better be sure you're not doing it for a frivolous reason."

"The other part of tort reform is to try to bring some rationality to payouts," Dr. Wilensky said. She advocated a \$250,000 cap on noneconomic damages and elimination of lump sum payments in favor of smaller payments over a period of time. She also recommended putting restraints on who could be sued, saying that sometimes "anyone within grabbing distance gets roped into the suit."

"We're not saying you can't sue, but this is a strong push for keeping cases out of court if possible, and then having the judgments be a little more rational," she said. ■

## Reform options weighed at Kane County conference

(Continued from page 1)

Simone, M.D., a Kane County Medical Society past president, who represented KCMS and ISMS views on the program.

"We need to address the concerns of the general public," Dr. Simone said, explaining the importance of debates on health care reform issues. "It's important to communicate what we feel is necessary for an adequate health system for the country."

"Health care reform is already coming about," he added. "I really think that health care reform in the way physicians practice has already been mandated

through Medicare. I don't think it's anything new; it's just a matter of degree. Do we want to have a single-payer national health insurance, or do we want to have a pluralistic system where people can assume some of the responsibility of health care themselves? It's been ongoing for many years, not something that's just occurring today."

Hastert provided attendees with an outline of a health care reform plan he supports that is based on ISMS principles and builds on the current system. He spoke on the need to encourage Americans to become prudent health care users, reform the malpractice system and decrease defensive medicine.

Presenting the three options were Mary Coleman, M.D., a pediatric neurologist and member of Physicians for a National Health Program; Stephen Zuckerman, Ph.D., a senior research associate from the Urban Institute, who presented the play-or-pay option; and market-based reform advocate Stuart Butler, Ph.D., director of domestic and economic policy for the Heritage Foundation.

Dr. Coleman advocated the single-payer national health care system, saying that the United States can learn from other countries' mistakes in building their national systems. "The United States is the only industrialized country without national health care," she said. "But we are defeated by calling it 'socialized medicine.'"

She cited overuse of emergency rooms, oversupply of hospital beds and catastrophic illnesses caused by delays in seeking health care as prime factors in health care costs. In Canada, she said, health care costs are much lower because

these problems do not exist.

Describing the play-or-pay system as "not a painless or simple solution," Dr. Zuckerman explained that it calls for employers to "play" by providing health insurance or "pay" a payroll tax for each employee into a state or national health care plan. He suggested that the two key factors of the plan would be the level of the payroll tax and the extent of the coverage provided.

"The tax rate plays a crucial role," Dr. Zuckerman said. "A low rate will result in employers opting to 'pay,' creating a large public plan. A high tax would prompt employers to 'play,' leading to a smaller public plan that could fall prey to the problems Medicaid has already suffered."

"The strength of the play-or-pay system is that it builds on the current structure," Dr. Zuckerman continued. "That means no change for most people with employer coverage." He estimated the cost to implement such a system would range from \$30 billion to \$40 billion, as opposed to the cost of a single-payer system, which he placed at \$200 billion. "Any plan will require some new funding," he said.

**THE MOST-APPLAUDED** proposal of the conference was market-based reform, presented by British economist Dr. Butler, who began his speech by calling a single-payer system "all the things that made the Soviet Union work so well." He called play-or-pay "unstable," saying that "people don't want to be forced to control costs."

Instead Dr. Butler recommended introducing dynamics that work in the rest of the economy. He identified elements of a workable system: allowing consumers to make choices without being rejected on the basis of pre-existing conditions; preventing insurers from changing the rules

"halfway through the game"; and creating an individual sense of responsibility for health care.

Under a market-based program, Medicaid and Medicare would be universal, Dr. Butler said, and a tax credit system for health insurance could be implemented. The system would rely on a method of cost control that works in the rest of the economy, allowing for more help for the needy, he said. If Medicare could not be kept intact, the elderly would still have options, including keeping the same plan at age 65 as they had at 64.

After the presentations, proponents of each reform plan were given time to rebut the other options. Panelists included Robert Creamer, executive director of Illinois Public Action, who praised the single-payer system as a "single insurance company, with no copayments or deductibles"; businessman Jack McEachern, president of Wayne Circuits, who decried filling out "tons of forms," and said that "government is not the solution, government is the problem"; and Dr. Simone, who urged that insurance companies not be allowed to discriminate against sick people and that individuals who buy their own insurance receive tax advantages.

Dr. Wilensky delivered the luncheon address, saying that people need to hear about the best ways to fix the health care system. She spoke on the need for Americans to understand all the options before a change is made and urged attendees not to choose a single-payer system for alleged administrative savings because "that makes no sense at all." ■



**Illinois Conference on Health Care attendees applaud debate on three health care reform options: the single-payer alternative; play-or-play; and market-based systems.**



# Physician speakers: Thanks for your dedication to our seniors program!

To address the health needs of an aging population and improve communication between physicians and senior patients, the Illinois State Medical Society established the "Partners for Health" outreach program two years ago.

Since the program's inception, more than 25,000 seniors have heard speeches by volunteer physicians on topics ranging from osteoporosis and high blood pressure to the rising cost of health care.

In April, the program won statewide recognition when it received the "Partners-in-Eldercare" Award from the American Association of Retired Persons. In receiving the award, ISMS joined nine other state agencies that have developed successful and innovative ways to improve the lives and health care of seniors in Illinois.

Currently, 241 physician speakers representing 45 Illinois counties are active members of the bureau. ISMS would like to thank all those dedicated physicians who participated in this year's program:

**Adams County Medical Society**  
Robert C. Murphy, M.D.

**Bureau County Medical Society**  
Gregg Davis, M.D.  
Louis P. Lukancic, M.D.

**Champaign County Medical Society**  
David L. Boyd III, M.D.  
B. Smith Hopkins, M.D.  
David W. Morse, M.D.

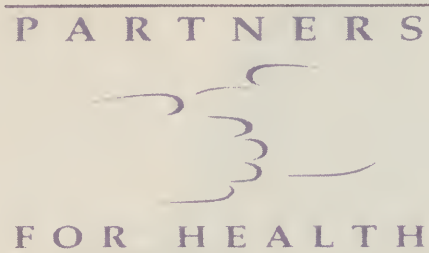
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Krystyna H. Berry, M.D.  
Richard A. Bloom, M.D.  
Victoria L. Braund, M.D.  
Donald E. Casey Jr., M.D.  
Mary E. Fry, M.D.  
Daniel F. Garvey, M.D.  
Joseph F. Hinkamp, M.D.  
Arthur Hoffman, M.D.  
Sheilendr Khipple, M.D.  
Daniel H. Litoff, M.D.  
Niva M. Lubin, M.D.  
Steven M. Malkin, M.D.  
Adolfo F. Molina, M.D.  
B. Michael Nagel, M.D.  
Thomas M. Nelson, D.O.  
Mehroo M. Patel, M.D.  
Aldo F. Pedroso, M.D.  
Leonard R. Robinson, M.D.  
Mark A. Rosanova, M.D.  
James F. Skomurski, M.D.  
Vasanth M. Surath, M.D.  
Dhruva R. Tilwalli, M.D.  
Mary F. Vanko, M.D.

**Christian County Medical Society**  
Jui-Long Yang, M.D.

**Coles-Cumberland County Medical Society**  
Kiran V. Joag, M.D.  
Jack P. Spaniol, M.D.

**DeKalb County Medical Society**  
Edward A. Hirsch, M.D.

**DuPage County Medical Society**  
Mohammed M. Arain, M.D.  
David Butler, M.D.  
Frank C. Chao, M.D.  
George J. Childs, M.D.  
Panagiotis J. Floros, M.D.  
Farouk F. Girgis, M.D.  
John J. Guido, M.D.



John A. Hamby, M.D.  
Aaron J. Lazar, M.D.  
Patricia A. Merwick, M.D.  
Morgan M. Meyer, M.D.  
M. Paul Meyer, M.D.  
Joseph R. O'Donnell, M.D.  
Ronald F. Pokornowski, M.D.  
John M. Saran, M.D.  
Julius P. Schweitzer, M.D.  
Cullen R. Schwemer, M.D.  
Greg E. Sharon, M.D.  
Mark Shields, M.D.  
Ramakrishna Thinakkal, M.D.

**Jackson County Medical Society**  
Oswaldo Ballesteros, M.D.  
Rebecca A. Hartman, M.D.  
Courtland L. Munroe, M.D.

**Jefferson-Hamilton County Medical Society**  
John Hall, M.D.

**Kane County Medical Society**  
Joong H. Choh, M.D.  
Robert E. Langman, D.O.  
Wayne N. Leimbach, M.D.

**Lake County Medical Society**  
Steven G. Ayre, M.D.  
Tien C. Cheng, M.D.  
Clarence D. Engstrom, M.D.  
James Hammond, M.D.  
Mira Kupisek, M.D.  
Jim I. McClure, M.D.  
James P. Monahan, M.D.  
Santo L. Ruggero, M.D.  
Mohammed Siddique, M.D.

**LaSalle County Medical Society**  
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German Gonzalo, M.D.  
Eleanor E. Howell, M.D.  
Richard A. Schmidt, M.D.

**Lee County Medical Society**  
Laxman S. Iyer, M.D.

**Logan County Medical Society**  
Robert B. Perry, M.D.

**Macomb County Medical Society**  
Jeffery W. Hemp, M.D.

**Macon County Medical Society**  
Otto C. Brosius, M.D.  
Charles F. Downing, M.D.  
Dhirendra K. Patel, M.D.

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James E. Segrist, M.D.

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John Boeren, M.D.  
Charles R. Frazer Jr., M.D.  
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Anwar A. Khan, M.D.  
Diane A. Megahy, M.D.  
William M. Price, M.D.  
Joseph S. Prosser, M.D.  
Dennis J. Stanczyk, M.D.  
Gary J. Vicik, M.D.

**Vermilion County Medical Society**  
Edward S. Warren, M.D.

**Washington County Medical Society**  
Gary A. Goforth, D.O.

**Will-Grundy County Medical Society**  
William A. DeWitt, M.D.  
Vincent S. DiGiulio, M.D.  
Stanley G. Rousonelos, M.D.  
Richard W. Zalar, M.D.

**Winnebago County Medical Society**  
Robert E. Heerens, M.D.  
Waseem Kamal, M.D.

Physicians interested in joining the ISMS "Partners for Health" speaker's bureau can call the public relations department at (312) 782-1654 or (800) 782-ISMS. ISMS will provide volunteer speakers with information about the program as well as public speaking tips.

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**August Employee of the Month**  
Phyllis Beverly, a Claims Division secretary in ISMS' Springfield office, accepts her award from ISMIS Vice President of Claims Tim Saunders.

## Springfield secretary is August Employee of the Month

[ CHICAGO ] A little more than a year of service to the Illinois State Medical Society was enough time for Phyllis Beverly to prove herself an outstanding employee. Beverly, one of two Claims Division secretaries based in the Springfield office, was named the ISMS Employee of the Month for August at an awards ceremony Aug. 10.

Tim Saunders, Illinois State Medical Insurance Services vice president of claims, presented Beverly with a plaque and a check for \$200, calling secretaries

the "backbone of every organization."

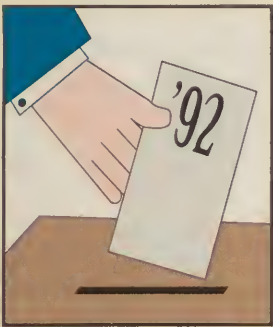
Saunders said Beverly's "enthusiasm and upbeat attitude create an atmosphere that makes everyone she works with glad to come to the office." Since she works daily with Illinois State Medical Inter-Insurance Exchange policyholders, Beverly has learned to prioritize, distinguishing emergencies from problems that can wait a few days.

"I really enjoy working here, and I'm impressed with everyone I've come in contact with," Beverly said, accepting

the award. "I'd like to work here until my old age."

Beverly joined the ISMIS in April 1991, bringing with her 18 years of secretarial experience. Her name will be inscribed on a plaque in the ISMS reception area listing each Employee of the Month.

All permanent, full-time ISMS/ISMIS employees – except those at senior management level – are eligible for the Employee of the Month award. Physicians who wish to nominate a staff member for the award should call the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



## What district are you in?

Physicians hoping to become informed about candidates for the U.S. Congress and the Illinois General Assembly in the November election may be wondering who their candidates are. Redistricting has changed congressional, legislative and representative boundaries, and in many cases, voters do not know which district they are now in.

For registered voters, the best way to find out may be to look at your *new* voter registration cards. Most counties and other local voting authorities have mailed voters new cards listing the new congressional, legislative and representative districts. State Senate candidates run in legislative districts and candidates for the Illinois House run in representative districts.

Or, call your county clerk. If you live in one of the following nine Illinois communities – Aurora, Bloomington, Chicago, Danville, East St. Louis, Galesburg, Peoria, Rockford or Springfield – call the municipal board of elections there. Physicians who still cannot determine their district can call the Illinois State Medical Society Governmental Affairs Division at (312) 782-1654 or (800) 782-ISMS.

One more thing. Unless you've registered to vote, the previous exercise will be futile. Fortunately, the county clerks or municipal boards of elections can take care of that, too. ■

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# HIV-infected nurse receives record judgment

**VERDICT:** Health care workers infected with HIV on the job begin to see huge awards for pain and suffering. By Anna Brown

[ ALBANY, NY ] In a record judgment against the state of New York, a nurse infected with HIV during a struggle with a patient was awarded \$4.5 million for pain and suffering, medical expenses and lost wages.

The unidentified nurse was infected in 1988 when she was stabbed in the hand with a hypodermic needle by an inmate

of the Mid-State Correctional Facility in Marcy, NY. John Balsan, who had been brought for treatment to Faxton Hospital in Utica, NY, had been struggling with hospital staff for 30 minutes when he stabbed the nurse. Balsan, who was serving a 2½-to-five-year sentence for possession of stolen property, died of congestive heart failure less than two

days after the incident. The nurse tested positive for HIV six months later.

New York State Court of Claims Judge Israel Margolis based his decision on what he termed the woman's "massive" suffering as a result of the incident. He awarded the nurse \$4.25 million for pain and suffering, and \$250,000 for medical expenses and lost wages. Her

husband was awarded an additional \$1 million for loss of consortium.

Margolis criticized two prison guards who, he said, did not act to help hospital staff subdue Balsan. He said the guards refused to assume their charged responsibilities and interfered with hospital staff by asking for gowns and gloves while the struggle ensued. When the items were provided, Margolis said, the guards refused to use them. Both are still employed at Mid-State. Margolis cited statistics indicating the probability that the nurse will not live past 1997. ■



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## Take action on incidents

(Continued from page 10)

**AFTER REPORTING THE INCIDENT,** physicians should forward a copy of medical records related to the incident to the claims analyst at the Exchange. From that point, the incident is in the Exchange's hands. If necessary, it will hire a physician-consultant to further investigate the incident by reviewing the medical records, evaluating the standard of care and fully documenting the details. The Exchange will establish an incident file for future use.

In addition to sending a copy of the medical records to the insurer, Nickels advises physicians to include a follow-up letter confirming that they have notified the insurer of the incident and supplied the appropriate documentation. "You don't need to go into great detail in the letter, but you should create a paper trail that indicates that information about the incident was relayed to the insurer," he said.

In the meantime, physicians should maintain normal communications with the patient and family members involved in the incident, Nickels advised. "Talk with the patient but don't apologize or say you made a mistake. Tell the patient you're concerned and explain your [treatment] plan for addressing the adverse result. But be careful to do so without attributing fault to yourself or your staff."

Hall concurred. "I recommend that the doctor show his or her human side and be sympathetic and empathetic to the patient and family, which is an extension of the bedside manner."

But physicians should be very careful that their condolences are not an admission of wrongdoing, Hall said. "It's all right to express sympathy and understanding for an adverse outcome, but it's very counterproductive to specifically say that they did something wrong, because that would be an admission by a party."

An admission of wrongdoing can return to haunt physicians because the patient or family member who heard it would generally be allowed to relate that fact to a jury at trial, according to Hall.

Physicians also should not offer to make amends for the problem by, for example, reducing the bill for services rendered, said Nickels. Above all, don't pretend the incident didn't occur and wait for it to go away, Nickels added. Those cases often cause problems later. ■



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# Peoria Medical Society Auxiliary wins national award

**ACCESS:** The Peoria Medical Society Auxiliary received national attention for funding a free clinic serving several downstate counties. By Gina Kimmey

[ PEORIA ] The Peoria Medical Society Auxiliary received the American Medical Association Auxiliary's prestigious Health Awareness Promotion Award for opening the Heartland Community Health Clinic in December 1991. The clinic serves more than 40,000 people in Peoria, Tazewell and Woodford counties without access to basic health care.

"Communities like Peoria have a strong history of banding together to solve problems," said Kristy Gorenz, Peoria Medical Society Auxiliary health promotions chairman. "The clinic was opened to meet the needs of those in our community who fall through the health care cracks."

A task force of the Peoria Medical Society, the Auxiliary and community leaders found that there were thousands of area residents without access to health care. In response, the Auxiliary donated \$18,400 and raised more than \$80,000 from the community to fund the clinic's opening and first-year operating expenses. The building that houses the clinic is

rented from the Catholic diocese for \$1 per month, and several medical families donated furniture and office equipment. Long-term maintenance and operating expenses will be paid by donations from the community, business and religious leaders, and continued support from the Auxiliary, said Gorenz.

The clinic, open 40 hours per week, is staffed entirely by volunteers. Between

50 and 75 Auxiliary members, nurses, technicians and receptionists oversee daily operations, including scheduling appointments, registering patients and dispensing medications. More than 160 doctors volunteer as well, treating patients at the clinic and the hospital; most work out of their offices on a consulting basis.

Since its opening, the clinic has han-

dled more than 2,000 patient visits and distributed approximately \$33,000 worth of free prescriptions. At first staffed only by past and present auxiliary members, the clinic now gets volunteers from all over the tri-county area.

The HAP awards recognize auxiliaries for "efforts to identify and address the health needs of people in their communities." Other winners announced at the AMA Auxiliary annual meeting were the Auxiliary to the Medical Society of Mobile County (Ala.) for their Partner-in-Education program, and the Mesa County (Colo.) Medical Society Auxiliary for their work to provide 5,000 children with vaccinations. ■

## ISMS seeks action

(Continued from page 1)

similar legislation previously. In related legislation, ISMS has petitioned the governor to protect the public by amending legislation so that a *referral and documented diagnosis from a physician, dentist or podiatrist* are required before a *naprapath* may treat a patient.

Cancer patients would have *insurance coverage for use of prescription drugs* for therapeutic purposes *other than their labeled use* if the governor signs S.B. 1533, which ISMS strongly supported this year. Dr. Freidheim told the governor that "off-label use" of drugs is "not experimental drugs but rather drugs which have been approved by the FDA and later found by the professional medical community to be effective for purposes other than those listed on the label."

He has also asked the governor to sign a bill augmenting *funding to hospital trauma centers* and to require Illinois hospitals to comply with *guidelines for resident work hours* established by the Accreditation Council for Graduate Medical Education. ACGME accredits all residency programs in the United States and is medical education's authority on resident work hour self-governance and reform.

If the governor signs H.B. 3619, physicians will be allowed an opportunity to review *Illinois Health Care Cost Containment Council* reports prior to release to ensure that hospital-generated data about them are valid prior to release to third parties. And the health care community, citizen groups and real estate agents would all work together to control lead poisoning if the governor signs the *Lead Poisoning Prevention Act*.

Alerting the governor to physicians' concerns about and support of legislation is an important phase of the ISMS advocacy program with elected government officials. ■



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## Health service priorities in Oregon

Examples of the priorities assigned to various medical conditions and treatments by the Oregon Health Services Commission. Under the proposal rejected by the federal government, the Oregon Medicaid program would have paid for services ranked 1 through 587, but not for procedures lower on the list.

Rank	Procedures paid for by Medicaid
2	Medical therapy for tuberculosis.
158	Medical therapy for AIDS.
366	Liver transplant for cirrhosis of the liver unrelated to alcohol.
510	Medical therapy for spina bifida.
583	Medical therapy for disk disorders in the cervical region of the spine.

Rank	Procedures not paid for by Medicaid
588	Medical therapy for disk disorders in the thoracic-lumbar region of the spine.
597	Medical therapy for viral hepatitis.
600	Breast reconstruction after mastectomy for breast cancer.
643	Medical therapy for chronic bronchitis.
669	Medical therapy for certain nonfatal viral infections, including viral pneumonia.
688	Cancer where treatment will not result in a 10 percent chance of survival for five years.
690	Liver transplant for alcoholic cirrhosis of the liver.
695	Medical therapy for common cold and acute upper respiratory infections.
702	Medical therapy for AIDS when patient is believed to be in the last six months of life.

Sources: Congressional Office of Technology Assessment; Oregon Health Services Commission.

## Oregon: A Medicaid plan tagged with the 'R' word

(Continued from page 1)

effort unlikely to succeed.

Opponents charged the plan discriminated against the disabled in establishing a priority list that undervalued the quality of life of the disabled. The state countered that the ranking was developed with extensive public input, including a public survey on quality of life issues. Oregon officials could not project when, or if, the state would resubmit the plan.

**OPTING TO DENY MEDICAID** coverage for some services in order to extend access to all Oregon citizens, the Oregon plan was the first to propose a prioritized services plan. With the concurrence of the Oregon Medical Association, the legislature — led by Sen. John Kitzhaber, M.D., president of the state Senate — had polled the state population through more than a year of town meetings and phone surveys to compile a list of medical services ranked by societal priorities.

"By guaranteeing that virtually everyone in the state will have access to the health care system, we shifted the debate from who is covered to what is covered," Dr. Kitzhaber told the Illinois State Medical Society Board of Trustees in a special presentation last year. "And this has allowed us to ... clarify the objectives of our health care policy and to evaluate the effectiveness and appropriateness of health care services."

A "cutoff" point of the final list of more than 700 services would be deter-

mined by the amount of money the state legislature budgeted for Medicaid in any given year. Services at the top of the list tended to include treatments for acute conditions that can be fatal, maternity care and preventive care.

To develop that list, the state conducted an extensive and broad-based survey of Oregon public opinion on the social values associated with medicine and health care: quality of life, equity and community compassion. More than 3,000 people participated in 53 public meetings held around the state. Panels of physicians developed information on the appropriateness, efficacy and outcomes of various procedures, providing more than 3,000 hours of volunteer time.

In 1991, the state legislature voted to fund the first 587 medical procedures and treatments on the Oregon Medicaid list, which totaled 709 services. Some of the reimbursed services on the list are not covered under the current Medicaid schedule: dental services, prescription drugs, hospice care and most transplants. Falling below the cutoff point were 122 procedures that included liver transplants to treat cirrhosis, ineffective care for extremely low-weight babies and ineffective care for people in the final stages of AIDS.

By restricting the number of services covered, Oregon hoped to increase the number of people covered. The state's current Medicaid program covers about 200,000 people, while state officials estimate another 100,000 below the poverty line are not covered. Over the next three years the plan would expand Medicaid coverage to include all citizens at or below the poverty line. By 1994, nearly all the 400,000 uninsured Oregonians would have health coverage — the only exceptions would be a few unemployed and self-employed people and students.

**MOST MEDIA ATTENTION** focused on the rationing aspect of the Oregon plan; little coverage was given to the plan's proposal that employers in the state be required to provide minimum coverage equal to the Medicaid plan to all employees.

Other elements of the plan would have permitted tax credits to small employers to encourage them to provide health care benefits to employees; a malpractice "shield" that would protect physicians and other providers from being sued for failing to provide procedures not covered by the state, and a shift to cost-based Medicaid reimbursement that would probably sharply increase Medicaid reimbursement levels in the state.

ISMS studied the Oregon plan, and while admitting that it may have limited merit, acknowledged that the side effects of rationing could not be evaluated. In Unfinished Business Report D (A-92), the ISMS House expressed doubt that state-specific proposals could truly address access to care problems. ■

*Editor's note: The next several issues of Illinois Medicine will include analyses of various health care reform proposals. These articles, intended to educate physicians, will also serve as useful material for community leaders, patients and legislators. Readers are encouraged to clip and copy these articles and distribute them widely.*

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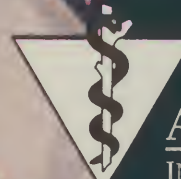
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For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

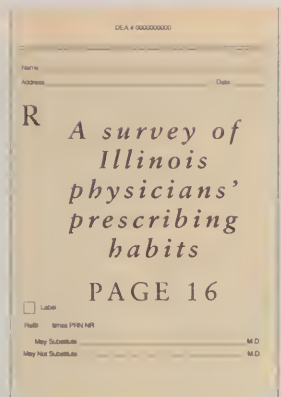
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Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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# Illinois Medicine

An overview of  
U.S. Senate  
and House  
candidates' views  
on health care

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ILLINOIS STATE MEDICAL SOCIETY • SEPTEMBER 11 1992

## U.S. Senate, several congressional races are of interest to physicians

**ELECTION:** Reasonably clear choices have been outlined on health care and tort reform in selected federal races. By Kevin O'Brien

This fall's campaign for the U.S. Senate and selected congressional seats features candidates whose positions provide physicians and others interested in health care reform and tort reform with reasonably clear choices.



payer, government-run universal health care system. Braun stayed above the fray and took advantage of demonstrative anti-incumbent sentiment to rack up 38 percent of the statewide vote to Dixon's 35 percent and Hofeld's 27 percent.

1992 has been dubbed the "year of the woman" in national politics, thanks in part to Cook County Recorder of Deeds Carol Moseley Braun's stunning upset victory over veteran Sen. Alan Dixon and trial lawyer Al Hofeld in the Democratic senatorial primary.

In a race that many observers say is of vital concern to Illinois physicians, Braun faces Rich Williamson, an attorney from suburban Cook County and former White House aide to President Reagan. Although some analysts view the campaign as a "race to the middle," others maintain it is a clear choice between a traditional liberal Democrat and conservative Republican. Although articulate on the issues and the beneficiary of a hugely successful publicity blitz targeted to media in Illinois during the Republican National Convention in Houston (Continued on page 26)

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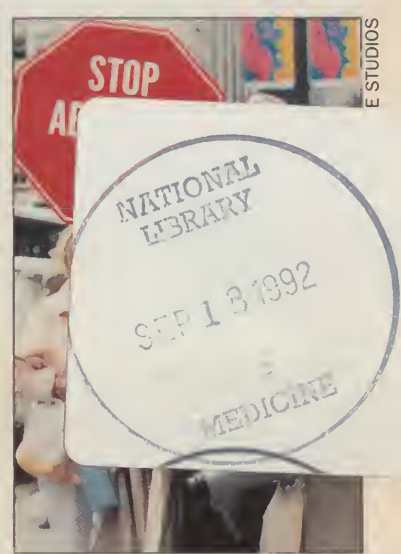
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## Elective abortions at Cook County Hospital to resume Sept. 17

**ABORTION:** An appellate judge's refusal to extend a temporary restraining order clears the way for abortions to resume at Cook County Hospital. By Kevin O'Brien

[ CHICAGO ] Elective abortions at Cook County Hospital will resume Sept. 17, Cook County Board President Richard J. Phelan announced Sept. 2. Phelan won a major legal victory Aug. 26, when a circuit court judge ruled Phelan had the authority to issue an executive order reinstating elective abortions at the public hospital.

Cook County Circuit Court Judge Thomas J. O'Brien lifted a temporary restraining order in a suit brought by five county commissioners challenging Phelan's authority to issue the order. The plaintiffs appealed, asking the Illinois Appellate Court to extend the TRO pending a hearing. The Appellate Court, however, Sept. 1 refused to grant the extension and scheduled a hearing for Oct. 14. Phelan said the procedure would be performed three days (Continued on page 26)



Joseph M. Scheidler, executive director of the Pro-Life Action League, has pledged to picket the homes of physicians who perform abortions at Cook County Hospital should abortions resume there.

### ISMS DRUGS AND THERAPEUTICS COMMITTEE

## DOCTORS REVIEW, RECOMMEND PUBLIC AID DRUG COVERAGE

[ CHICAGO ] The committee that recommends new drug products for coverage by the Illinois Department of Public Aid has been working as hard as ever in 1992. The group, which meets several times a year to review and recommend products, must also secure the concurring approval of the Illinois State Medical Society Board of Trustees. At its meeting Aug. 12, the committee recommended several products for approval, and reviewed a manufacturer's appeal, said Joseph B. Perez, M.D., committee chairman.

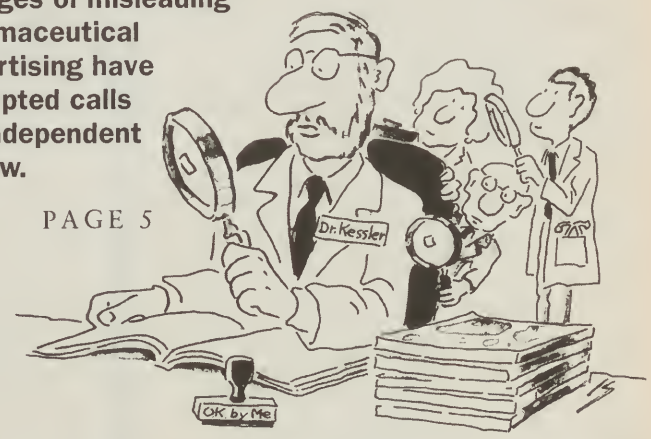
"We reviewed many new [products] this year," Dr. Perez said, noting that a high percentage of reviewed drugs are approved by the committee.

The 11 physicians on the panel study manufacturers' literature of each product to be reviewed. One factor in recommending a product is the expertise of their peers, as the committee is made up of physicians in a variety of specialties.

"We look for unique functions and compare them to medications already on the (Continued on page 25)

Charges of misleading pharmaceutical advertising have prompted calls for independent review.

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## Springfield City Council votes down health care referendum

[ SPRINGFIELD ] The Springfield City Council Aug. 18 blocked a proposal to place an advisory referendum on national health care on its November municipal ballot. The City Council split 5-5 on the proposal. Presented as an emergency resolution, it required seven votes for approval. Illinois State Medical Society Fifth District Trustee Jane L. Jackman, M.D., testified in opposition to the resolution.

The proposed referendum was identical to State Treasurer Patrick Quinn's initiative, which failed to receive General Assembly approval for the statewide ballot but which the Cook County Board of Commissioners approved June 15 for the Cook County ballot. The referendum states: *Should the U.S. Congress and the President of the United States enact a publicly-funded National Health Insurance Program that provides comprehensive health care for all citizens while giving everyone the right to choose their own hospital, doctor or other health care professional?*

So far, only Cook County voters will have the option of voting on the referendum, although other Illinois counties or municipalities may be considering similar initiatives.

## FDA cracks down on overseas pharmacies

[ ROCKVILLE, MD ] The U.S. Food and Drug Administration has taken a strong stance against several offshore pharmacies' promoting their products to cost-conscious consumers in this country.

Advertisements for the unapproved drugs claim the products are cheaper than prescription medications. The FDA maintains that due to their unknown quality and insufficient directions for their use, these drugs may instead pose serious patient health risks.

"In some cases, the drugs are counterfeit — lacking any real similarity to the approved drug. The uncertain character and quality of these drugs constitute an unreasonable risk to the public health," said David Kessler, M.D., FDA commissioner.

An FDA "import alert" released in January requires FDA field offices to hold all imported unapproved prescription medications manufactured by six overseas companies that have promoted their products in this country.

The medications, advertised in magazines and through direct mail, are designed to treat conditions such as depression, high blood pressure, fatigue, chronic bronchitis and hair loss.

The companies listed in the alert are Interpharm Inc., of Nassau, Bahamas; Northam Medication Service International Pharmacy of Nassau, Bahamas; Inhome Services of Delemont, Switzerland; International Products of Hannover, Germany; Azteca Trio International, S.A. de C.V., of Zona Rio Tijuana, Mexico; and Interlab of London, England.

The FDA alert will not affect the importation of small dosages of drugs

not yet approved in the United States for individuals with serious illnesses.

These "personal-use" drugs are allowed provided they do not pose health safety risks, are not promoted in this country and are used only for serious conditions for which no treatment is available here. The FDA allows the importation of personal-use drugs in treatment quantities of only three months or less.

## Drug prices rise at three times rate of inflation

[ WASHINGTON, D.C. ] Over the last six years, the prices of prescription drugs have increased at three times the rate of inflation, according to a study from the General Accounting Office.

The study analyzed several prescription medications mentioned in consumer complaints about price increases to the House of Representatives' Subcommittee on Health. Of the 29 medicines studied, the prices of 19 increased by more than 100 percent from 1985 to 1991. During the same time, the U.S. Consumer Price Index of all prescription drugs increased by 67 percent; the inflation rate was 26.2 percent.

The cost of medical care rose by 56.3 percent during that time, the GAO study found.

## PMA directory lists free drug programs for needy patients

[ WASHINGTON, D.C. ] The Pharmaceutical Manufacturers Association has developed a directory to help physicians identify the increasing number of charity drug programs available for indi-



U.S. REP. JOHN W. COX JR. (D-Galena, right), confers with Winnebago County Medical Society President Jerome S. Weiskopf, M.D. (center), and Jay S. Weller, M.D. Cox and Donald Manzullo, his Republican challenger in the 16th Congressional District race, addressed the county medical society's Aug. 24 meeting.

gent patients. The directory lists 59 programs offered by 44 of the association's member companies.

"[The PMA] has had a long-standing tradition of supplying drugs to indigents, but until now, this information was not well publicized," said Judith Shuler, the PMA's assistant vice president of communications. "This directory will make it easier [for physicians] to identify programs that are available."

Program entries include the name and company providing the program, information on how to request assistance, the prescription medicines covered and other basic eligibility requirements. Also included is a PMA hot line number for physicians who have specific questions.

Physicians can receive a free copy of the directory by writing to 1992 Directory of Pharmaceutical Indigent Programs, Pharmaceutical Manufacturers Association,

1100 15th St. NW, Washington, D.C. 20005.

## Cancer drug sales exceed \$1 billion

[ NEW YORK ] Sales of cancer drugs in 1991 topped \$1 billion for the first time in history, according to a study conducted by the New York-based research and consulting company FIND/SVP. The drugs were purchased in an attempt to cure existing cases and the 1.1 million new cancer cases in 1991.

As the nation's No. 1 killer, cancer was responsible for 514,000 deaths in 1991. FIND/SVP predicts that the continuing rise in new cases and fatalities will increase cancer drug sales 11.8 percent this year, to reach a total of \$1.23 billion. After that, the group expects a 10.4-percent annual growth rate to be maintained through 1996, when sales could reach \$1.8 billion.

The number of new cancer-fighting drugs is also increasing quickly. The study noted 10 new products recently approved by the FDA, with 85 still in the approval process. In addition, three new therapies are being developed: photodynamic therapy, a method of photosensitizing and destroying tumors; ongene and tumor suppressor therapies, which stimulate genes that can help attack tumors or interfere with their growth; and antisense therapy, which binds with mRNA to confuse the genetic makeup of cancer cells.

Despite the increase in new cases of cancer, the National Cancer Institute

## PHYSICIAN FACTS

### Yellow Pages good for business

Following are several of the most-referred-to products and services, ranked by estimated number of annual references.

Product/service	Estimate (in millions)
Physicians/medical — physicians & surgeons	1,050
Automotive — auto parts new & used	887
Pizza	602
Attorneys/lawyers	312
Beauty salons	300
Hospitals/nursing homes — hospitals	250
Banks	237

Source: Yellow Pages Publishers Association. Estimates are based on three years of data through 1991.

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reported that 44 percent of people afflicted with cancer in 1981 survived the past 10 years. In the 1960s, such remissions were uncommon, FIND/SVP reports.

"The bottom line is that more people are getting cancer, and more people are surviving it," said Peter J. Allen, FIND/SVP vice president for market research, who believes that a single treatment for cancer is unlikely. ■

## AMA softens stance on drug ads targeted to consumers

[ CHICAGO ] After several years of opposition, the American Medical Association has softened its stance against prescription drug advertisements targeted to consumers.

During the AMA's annual meeting in June, the House of Delegates adopted a board report approving the ads on a case-by-case basis, provided they meet specific requirements.

According to the board, the ads must contain a "clear, accurate and responsible education or disease prevention message" and refer patients to their physicians for additional information.

In addition, the AMA considers it essential that the ads alert consumers to new treatments, encourage people to seek medical advice for conditions that would otherwise not be treated and include full prescribing information in layman's terms.

The guidelines also encourage advertisements that promote physician-patient communication and increase patient responsibility for healthy lifestyles.

The AMA's change in policy is a result of the public's increasing demands for health information and the AMA's responsibility in setting standards against which these types of ads can be measured, the report said. ■

## Medical equipment needed overseas

[ CHICAGO ] Don't throw away that old x-ray machine. The American Overseas Medical Aid Association is collecting unwanted medical equipment and supplies for distribution to former Eastern Bloc countries and the Third World.

"We accept almost anything," said Eugene Maurey, an association trustee. "We'll find someone who will want it. We'll give to any country in need, and there are so many. It's unbelievable, the letters we get."

Maurey, who also distributes medical equipment through Rotary International, said Overseas Medical Aid is looking for medical equipment, instruments, supplies, therapeutic drugs and bandages. The association currently is seeking cribs and hospital beds for adults and children in Paraguay and "enormous quantities of any supplies" to send to Ethiopia, he said.

All donations to the association are tax deductible. For more information or to make a donation, call Maurey at (312) 581-4555 or write the American Overseas Medical Aid Association, 4555 W. 60th St., Chicago, Ill. 60629. ■

## FDA rejects over-the-counter claims

[ CHICAGO ] "Prove it or move it" is the message from the U.S. Food and Drug Administration to manufacturers of over-the-counter medications. In August the FDA proposed banning 415 ingredients from seven categories of non-prescription drugs. "We are taking this action because no proof has been submitted to the FDA that shows the ingredients are effective for the conditions claimed," said FDA Commissioner

David A. Kessler, M.D. The products affected include remedies for digestive disorders, menstrual problems, fever blisters and poison ivy.

The ban on some ingredients is not total. An ingredient banned for one use may be allowed for another, and ingredients known to be safe but not effective can be listed as inactive ingredients. For example, salicylic acid is banned as an external pain reliever in insect bite and sting treatments but can still be used for removal of warts, corns and calluses. Peppermint, though not effective as a digestive aid, can be included as a flavor-

ing agent.

Two years ago the FDA banned 223 ingredients from 19 categories of products, and in 1991 banned 111 ineffective weight-control ingredients. The current proposal allows for a 60-day comment period including an opportunity for a public hearing. The FDA will then issue a final regulation setting a standard or recipe of acceptable ingredients, doses, formulations and instructions, as well as permitted claims. Manufacturers will have to reformulate or remove such products from the market before the final regulation becomes effective. ■

# Blue Cross Blue Shield



## REPORT FOR *Illinois Physicians*

### The Provider Assistance Unit

*Meeting Your Needs for Membership, Benefit, and Claim Status  
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When you call Blue Cross and Blue Shield of Illinois' Provider Assistance Unit at (312) 938-7340 for membership, benefit, and claim status information on your patients, you're greeted by the Voice Response Unit, an automated inquiry system designed to meet your needs quickly and efficiently. Benefit information available by touch-tone telephone will indicate overall benefit provisions including MSA, PPO, Deductible, Out-of-Pocket Limit, Maximum, and Coinsurance for many of your BCBSI patients. Callers may make multiple inquiries during each telephone call to the Provider Assistance Unit and, for more complex inquiries, always have the option of speaking with a service representative if they wish.

All you need to use the Voice Response Unit is your patient's group and membership numbers -- both available on your patient's BCBSI identification card -- and your Blue Shield Provider Number.

For more information on the Voice Response Unit, please contact the BCBSI Provider Assistance Unit at (312) 938-7340 for a copy of the Voice Response Unit (VRU) User's Guide.

### Precertification: City of Chicago

*Reminder:* effective June 1st, 1992, Blue Cross and Blue Shield of Illinois no longer reviews hospital admissions, surgical procedures or outpatient psychiatric or substance abuse services for City of Chicago employees, retirees, or dependents. Providers are instructed to call The Sunderbruch Corporation at (800) 373-3727 for admissions occurring on or after June 1st or for admissions expected to extend past June 1st, The Sunderbruch Corporation is conducting hospital review. For questions relating to this change, please call the City's Benefits Management Office at (312) 408-7210.

### Important Telephone Numbers for Professional Providers

HMO Illinois (Enrollment)	(312) 938-7453
HMO Illinois (Claim Inquiries)	(800) 892-2803
Managed Care Network Preferred (MCNP)	(312) 938-7433
Medicare Part B	(618) 997-3190
Provider Assistance Unit	(312) 938-7340
Provider File Changes *	(312) 938-6001

\* Request for Blue Shield Provider Number,  
Change of Address, Tax ID Change, Name Change

(9/11/92)

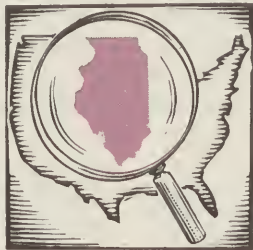


## Awaiting the governor's nod and the state's money

**PRESCRIPTIONS:** Two prescription-drug-related bills are on the governor's desk, as the state gets further behind on pharmacy Medicaid payments. By Kevin O'Brien

[ CHICAGO ] As Illinois physicians awaited the governor's decision on two pieces of prescription-drug-related legislation, Illinois pharmacists — like doctors — wait to get paid.

Gov. Jim Edgar Sept. 1 signed S.B. 1533. The Illinois State Medical Society-supported cover prescription drugs for certain types



bill, sponsored by Sen. Penny Severns (D-Decatur) and Rep. John F. Dunn (D-Decatur), was passed June 11 and sent to the governor July 7.

S.B. 1533 prohibits all group health insurance policies and HMOs that

of cancer from excluding coverage of these same drugs, if prescribed by a physician, for other types of cancer when the drugs have not yet received U.S. Food and Drug Administration approval for the "off-label" use.

In a letter to Edgar, ISMS Board of Trustees Chairman Jere E. Freidheim, M.D., noted: "Off-label use of cancer drugs is widespread. In fact, a third of all

drug administrations to cancer patients is off-label, and more than half of all cancer patients receive at least one off-label drug."

Dr. Freidheim emphasized that these drugs all had received FDA approval but that the professional medical community had found them to be effective for purposes other than those listed on the label. He strongly urged the governor to sign the bill.

**ANOTHER BILL AWAITING** gubernatorial action would create regulation requirements for mail-order pharmacies under the state's Pharmacy Practice Act. The provision contained in S.B. 1769 would codify policy adopted by the ISMS House of Delegates in 1990.

Among other provisions, the bill requires out-of-state mail-order pharmacies to register in Illinois and certify that they are licensed in the state where they are located. The pharmacies will also be required to provide a toll-free telephone service for use by Illinois patients and pharmacists. The toll-free number must be operable at least six days per week for a minimum of 40 hours per week and must be included on the label of each drug dispensed. The bill went to the governor July 30, which gives him until Sept. 28 to act.

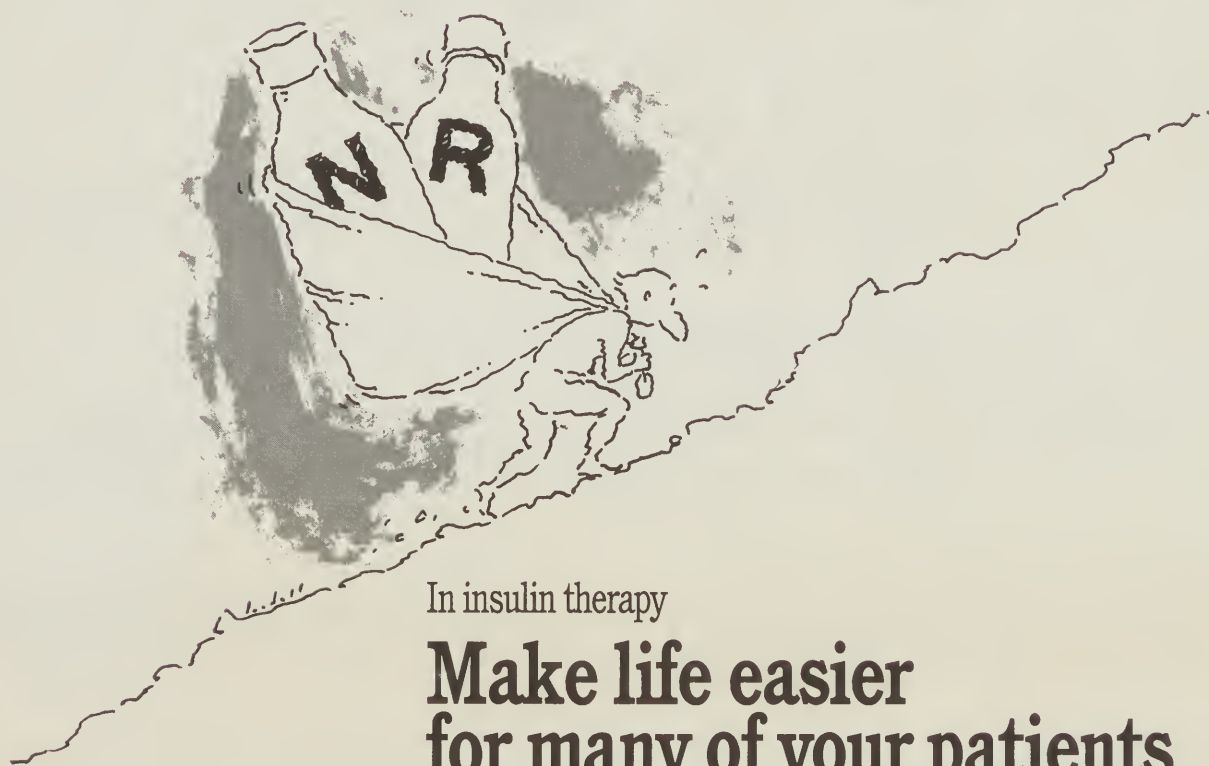
With all legislation sent to the governor, Edgar has 60 days to exercise one of three options. He can sign the legislation, whereupon it becomes law at the effective date cited in the bill. Or, he can veto the bill and return it to the General Assembly, which may attempt to override the veto. An override requires a three-fifths majority of each house. From the time it receives the bill from the governor, each house has 15 days to act. The governor can also amendatorially veto the legislation. In that case, each house may reject or concur with the governor's recommended changes.

**AS OF AUG. 14,** ILLINOIS pharmacists were owed \$77.1 million in overdue Medicaid prescription drug reimbursements, and physicians and other noninstitutional providers were owed \$102.2 million, according to the Illinois Department of Public Aid. Pharmacies are often the last in the chain of IDPA creditors to be paid, a situation that has caused severe financial strain to some pharmacies and caused others to close.

IDPA spokesman Dean Schott said that the bills keep mounting despite the more than \$40 million that was paid during the third week of July to pharmacists alone.

Illinois Comptroller Dawn Clark Netsch announced Aug. 25 that as a result of a \$600 million loan the state acquired the previous week, her office had begun processing Medicaid reimbursements to institutions covered by the hospital assessment plan. As of Aug. 25, the backlog of unpaid bills in the comptroller's office stood at \$495.8 million, most of which is owed to hospitals and nursing homes, she said.

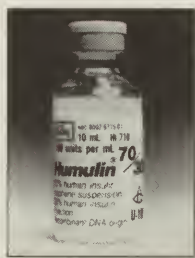
Unfortunately, pharmacists and physicians will not see any of those funds. But Schott and a spokesman for the comptroller said the loan should relieve some of the pressure on general revenue funds, which are used to pay noninstitutional providers. As of Aug. 24, the comptroller had bills for processing totaling \$44.7 million to pharmacists and \$38 million to physicians. ■



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# Pharmaceutical ads — truth in advertising?

**ADVERTISING:** Charges of misleading pharmaceutical advertising have prompted calls for independent review. By Stacie Crozier

[ CHICAGO ] It's been a long, hot summer for the pharmaceutical industry.

A study published in the June issue of the *Annals of Internal Medicine* threw a hot potato to the pharmaceutical industry, charging that most drug ads are incomplete at best and, at worst, just plain inaccurate.

Seething pharmaceutical companies countercharged that the study, conducted by University of California at Los Angeles researchers, is flawed. The industry claims physicians find drug ads useful in learning about new products but don't rely solely on ads to make prescribing decisions.

The study and the subsequent release by a Washington, D.C., consumer group of the names of products and companies involved prompted heated debate on how the U.S. Food and Drug Administration polices pharmaceutical advertising. It also raised the issue of patient safety — how do physicians choose new drug therapies for their patients?

Michael Wilkes, M.D., Ph.D., the study's lead author and a professor at UCLA, defends his findings. Although the study has been criticized by the pharmaceutical industry for scrutinizing ads as if they were content for refereed journals, he said that wasn't the case.

"We did not review ads as if they were journal articles," Dr. Wilkes said. "We developed evaluation criteria based on FDA standards for pharmaceutical ads. What reviewing articles and ads do have in common, though, is accuracy, honesty and truthfulness. We did use those important criteria."

**STUDY REVIEWERS FOUND** many problems in the ads they examined, such as lack of information on safety, efficacy, appropriate populations, side effects, and contraindications or needed references; and inclusion of misleading references, statements, graphs, tables or images.

Dr. Wilkes said he was surprised when Public Citizen Health Research Group, a Washington, D.C.-based consumer group, released the names of the companies and the drug ads used in the study. The group was able to access the information through the federal Freedom of Information Act because the U.S. Department of Health and Human Services provided support for the study.

"Public Citizen went to a lot of trouble to get that information," he said, "but I wasn't upset that they did it. The medical community has been complacent about this problem for too long."

Several studies before this one, he added, have shown "conclusively that physicians are definitely influenced by promotional activities" of pharmaceutical companies.

"You don't have to be a rocket scientist to understand why these companies pour so much money into advertising their products," Dr. Wilkes said. "It works."

"We really disagree vigorously with the assumption that advertisements should be scrutinized with the same standards as peer review articles, and it seems that is what this study did," said Jeremy Heymsfeld, director of corporate

communications for SmithKline Beecham, a Philadelphia company whose ads were included in the study. "All our ads meet FDA regulations, and they go through a rigorous internal review to ensure they do."

**PHYSICIAN AND PHARMACIST** reviewers found that 92 percent of 109 ads reviewed required major or minor revision, or were "unacceptable." A dozen of

SmithKline Beecham's ads were included in the study, according to Public Citizen. None were found to be acceptable by reviewers.

Heymsfeld says his company was not aware its ads were under study until Public Citizen released the names of the drugs advertised by 39 pharmaceutical companies in 10 medical journals.

"That was how we were able to determine what ads they were talking about," Heymsfeld said.

"Since then, we've looked at those ads again and still stand by the fact that our ads are designed to meet FDA requirements."

The Pharmaceutical Manufacturers Association, noting that "prescription drug advertising is the most regulated form of advertising in the United States," issued a strong objection to study findings.

"It is unfair to review 109 unidentified advertisements and claim that 92 percent of them, potentially, do not comply with FDA standards, thus impugning the reputation of an entire industry," a PMA news release stated. "The information provided in the article is simply inadequate for making value judgments."

Although pharmaceutical companies are not required to submit their ads to the FDA for approval before running them, ads must meet specific agency standards, explained an FDA spokesman. Under the guidance of Commissioner David Kessler, M.D., the agency has expanded its review activities since 1990.

About 100 times a year, the FDA requires pharmaceutical manufacturers to print a "remedial ad" in response to some

infraction of FDA standards, said agency spokesman Monica Revelle.

"It's a very rare occurrence, considering how many companies there are and how many advertisements they run," Revelle said. "The remedial ads are required to have a small photo of the original ad that ran along with an explanation of what the problem was."

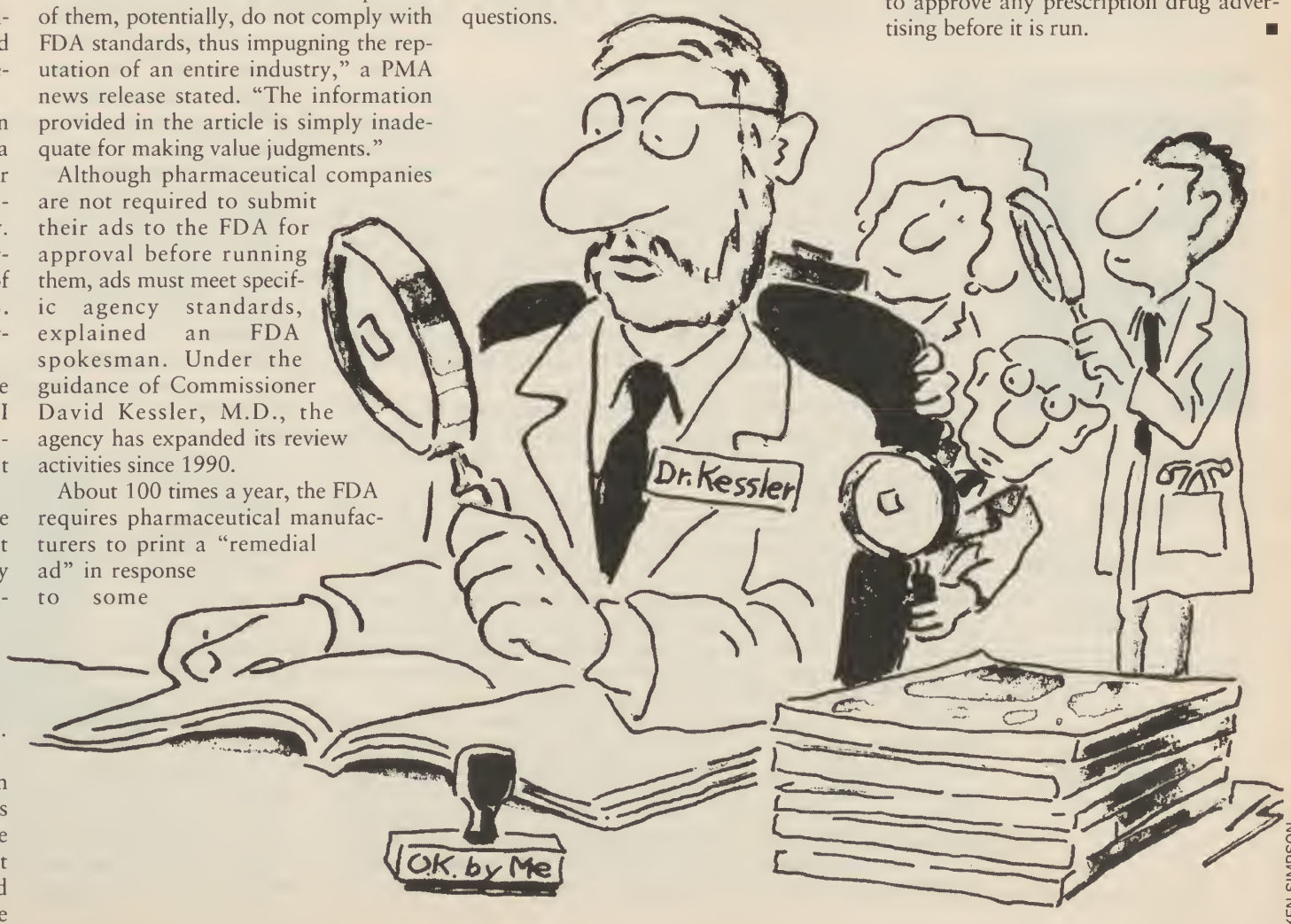
In an *Annals of Internal Medicine* editorial, Dr. Kessler writes that the "problem of misleading drug advertisements is real" and "needless injury or even death may occur" because pharmaceutical companies persuade physicians through advertisements to prescribe drugs that may not be appropriate.

Another company that had three of four of its ads in the study deemed unacceptable, Lederle Laboratories of Wayne, N.J., "appreciates the FDA's concerns about accuracy in pharmaceutical advertising," said spokesman Pat Fiachetti. "We have a good working relationship with FDA and do everything possible to ensure our ads meet their standards."

Fiachetti says that advertising is only one way Lederle communicates new product information to physicians. Other lines of communication include direct mail programs and medical meetings at which company representatives answer clinicians' questions.

*"You'd be hard-pressed to find a group more independent-minded than physicians, and it's up to them to decide what's best for their patients."*

GLAXO SPOKESMAN  
RICK SLUDER



"We hope that a combination of efforts will educate physicians about our new products and help them prescribe the best possible products for their patients," she added.

Rick Sluder, spokesman for Glaxo, said ads produced by his company must "pass muster with staff physicians, regulatory affairs personnel and legal staff before they are placed."

The Research Triangle Park, N.C., company tries to provide physicians with scientifically accurate and medically useful information without interfering in the physician-patient relationship, Sluder added.

Two of five Glaxo ads reviewed in the study were judged unacceptable. "Our ad review is a very exacting process that we feel meets FDA standards," he said. "Ads are designed to help physicians, but I don't think they rely only on ads for their information. You'd be hard-pressed to find a group more independent-minded than physicians, and it's up to them to decide what's best for their patients."

Audrey Ashbey, spokesman for Wyeth-Ayerst Laboratories in Philadelphia, said the company is committed to providing accurate, ethical and balanced advertisements for its products.

"Every ad is carefully reviewed to meet FDA and other industry standards," she said. "We're so careful with our ads. I can't stress that enough."

The UCLA study cited four of five of Wyeth-Ayerst's ads as unacceptable.

Public Citizen has petitioned Sen. Edward Kennedy's help to support the proposed "Integrity in Prescription Drug Advertising Act of 1992," now before Congress. That legislation would eliminate tax deductions for all prescription drug advertisements targeted to patients and health care professionals and the tax-exempt status of medical organizations whose journals publish unreviewed drug ads.

The consumer group recommends an independent review board be established to approve any prescription drug advertising before it is run.



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## EDITORIAL

# Hail to the chief

As the president travels towards the meeting site, he is briefed on the key issues of this constituency: the hot spots, the concerns, the biggest story in the local media today and how it impacts the group he's about to address.

There are almost always reporters to be dealt with: a stop at a TV station on the way to the dinner, a brief radio interview in the lobby before going into the meeting room. Sometimes the interviews are squeezed in on the car phone, when weather disrupts the travel schedule.

At the meeting, the president is introduced by the leading local dignitary to the other VIPs present; the time before dinner is usually brief, and meeting attendees are eager to use the time for personal greetings and renewing acquaintances. It sometimes happens that someone at the meeting has a problem that only the administration can handle: Someone writes down the particulars and promises a response.

Dinner isn't always chicken – it just seems that way. After dinner a number of other people speak before the president does, and although he really needs no introduction, he always gets one.

His speech reflects the tenor of the times and the priorities of the area. It's as personal as possible, as timely as it can be. If there's time, he'll take questions.

Usually there's time for a photograph, another round of handshakes and thank-yous and then it's back in the car, for the drive back. It's been a long day, and with luck the president can sleep a little

on the way.

Are we talking about George Bush? Or are we talking about Arvind Goyal, Bob Reardon and Jim Andersen?

It could be any one – the difference is one of timing. The campaigning president of the United States will work this kind of pre-election schedule full time from now until the election. For the president of the Illinois State Medical Society, this activity begins after he's elected and installed.

From September until April, the president of the medical society is on the road once or twice a week, heading out of the office, away from home and family, to spend evenings with the county medical societies, to visit with hospital medical staffs, to sit down with the media in big and small towns across the state, carrying the ISMS message about public health issues, health care reform, and doctors and their patients.

Even more important than the message the president takes with him to the counties is the information he brings back: the concerns, the questions, the input from the practicing doctors in Muddy, in Galena, in Peoria and in Highland Park. The president's tour is about communication, about the information exchange that makes the medical society truly representative of its membership, that keeps the ideas flowing.

Check your county medical society calendar now and see when the ISMS president will be visiting – make a note on your own calendar to be sure to be there. Because he's there for you.

## PRESIDENT'S LETTER

# Immunization increases costs but saves lives

By Arvind K. Goyal, M.D.



*"A universal compliance with vaccination requirements must be ensured quickly."*

Somebody told me the story of a man who lost his fortune in the stock market and now won't even read a book with margins in it. I have a patient who developed polio just before the Salk vaccine was marketed. You bet his children get every immunization on time.

Recent news reports continue to draw attention to many cases of measles still occurring, but shouldn't. Some other diseases ought to be outlawed as well, especially with safe and effective vaccines already available. There must then be some other roadblocks out there. Could those realities be the costs, the access, the inconvenience of having to go for not one but shot after shot, fear of side effects, lack of awareness or denial, "my kids can't get measles." Or could it be increasing bureaucracy adding to the reluctance of some physicians offering immunizations.

In the 1989/90 surge of measles cases in Illinois, many of the 4,569 patients afflicted with the disease were in the pre-school age group, where currently, there is no way to regulate compliance with the established immunization schedule.

The national childhood vaccine injury compensation act of 1986, with all its good intentions, increased documentation requirements each time a covered vaccine was administered. An informational pamphlet is now required to be provided when a vaccine is administered. That in itself does not constitute an informed consent – not by my book. And worse, the cost of several most commonly used and needed vaccines almost doubled. That, they said, would allow for funding to compensate legitimate victims who developed rare but real complication from vaccines. So, everybody pays, nobody wins! Again!

And then, recommendations for additional immunization requirements for everybody keep rolling in, without any regard to the cost or acknowledgment of past failures. There is then the risk that these new requirements may detract from other immunization efforts, which may be "more necessary." Such is the case of Hepatitis B vaccine which may be good medicine for certain high risk population groups, but the practicality, the cost efficiency and the wisdom of requiring every newborn from this point on to get three dosages of a vaccine that costs \$85.00

per dose is questionable.

The vaccine costs vary tremendously – as an example government pays \$15.00 for a single dose of MMR vaccine but physicians who purchase the vaccine from the same manufacturer as the government usually pay the list price of \$32.50. There are no generics available, no discounting or group purchase programs.

The logical necessity of boosters to maintain protective immunity levels also increases costs and inconvenience, and decreases compliance.

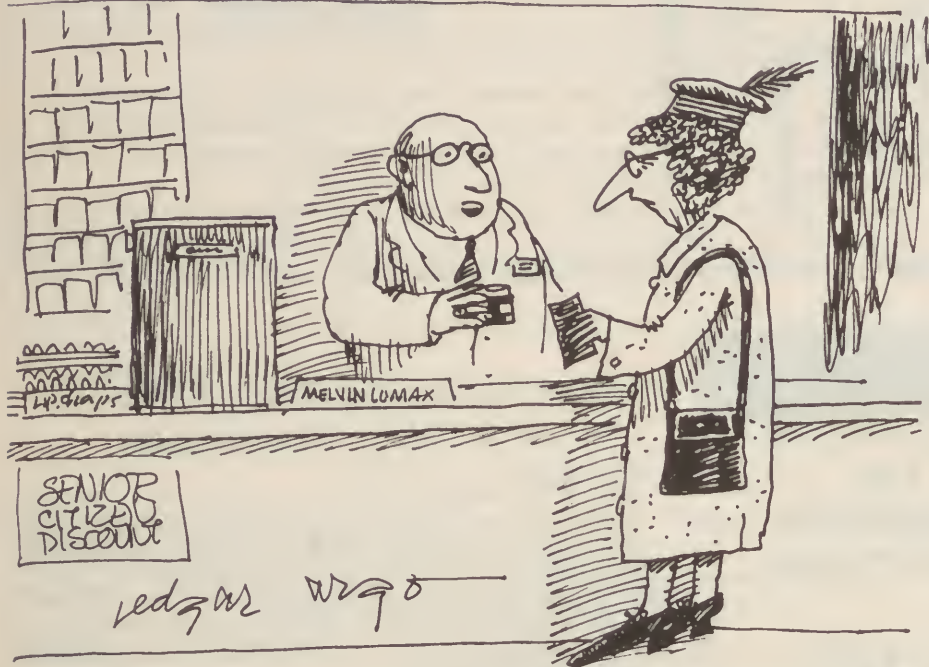
A universal compliance with vaccination requirements must be ensured quickly. Here, then, are my two cents, my suggestions, to fix this mess:

1. Cost of vaccines must be standardized. It may be a proper role for the government to enter the market to make low cost generic vaccines available at cost, if private industry is unable to do so with marginal profits.
2. All requirements for new vaccines and more paper work must be carefully weighed and approved by physicians, economists as well as consumers.
3. All required vaccines must remain available at local public health clinics at hours when the working poor can get there.
4. Research must focus not only on developing newer vaccines but also on simplifying existing immunization schedules.
5. Encourage new immigrants to get all required immunizations.
6. Develop innovative ways to enhance parental education and compliance with vaccination requirements for themselves and their children.
7. Physicians in all specialties should be encouraged to familiarize themselves with immunization requirements and use patient encounters to update immunizations.
8. All health insurance policies, HMOs, and governmental programs should cover required immunizations.

Your Society needs your input to develop what would be a successful plan so all our patients are immune from deadly measles, tetanus, polio and the like. We must, if we can, prevent them, for prevention is cheaper and more likely than cure!



# PRESCRIPTIONS



"This is a real miracle drug. ... It costs the same as it did last year."

## GUEST EDITORIAL

### Confessions of a detail man

It was once said that "everyone and everything, even the smallest flea, is part of me." So that you won't mistake this bit of prose as being Shakespearean, I should admit that I composed this masterpiece when I was a youngster trying to fit in with my surroundings while earning extra credit in English class.

Now, as an adult, I can relate even better to the flea – because I am a pharmaceutical representative. Some physicians will stop reading here due to their feeling that the life of a flea would be an improvement for my colleagues and me. I would strongly disagree with this position, however. When was the last time a flea gave you a pen with the name of a new "miracle drug" plastered all over it?

I believe physicians can greatly appreciate life's value and fragility. That is why I am asking you, the physician, to adopt a cutting-edge, dynamic, groundbreaking and state-of-the-art (drug rep lingo) state of mind. To revert back to poetry, "The selling of drugs, doesn't make me a thug, so please look at me, at least like a flea."

In all seriousness, I spent the better part of three months in training for my specialty – cardiovascular products. I spend 10 hours a day discussing them with physicians. I have the opportunity to encounter many different philosophies from many different physicians. In this regard, I, and other pharmaceutical representatives, can be an excellent and timely resource for information for you.

Most reps would agree that your being up front

and honest is appreciated. As you are our clients, patients are yours. Tell us your concerns and problems, as patients would tell you theirs. I am sure you would agree that your dialogue with your patients allows you to better diagnose their condition and thus do your job better. If given an opportunity, I believe drug reps may surprise you with their knowledge and may even broaden yours. However, if the reps don't know your concerns, they are just blowing hot air and, I would agree, are truly wasting your time. They should be swatted away like fleas.

I was recently told a classic story in which a new rep was in a doctor's office giving the most thorough and creative detail of his career to an elderly gentleman prospect. By the time the rep was finished, he had a commitment from the prospect to use the product exclusively. The only problem was that the prospect was actually a patient. The chances of his going to medical school were pretty slim.

The point here is that unless you want representatives detailing your patients in the waiting room, let us in and ask us a question or two while we're there.

In conclusion, a final attempt at poetry: "A flea is something we bemoan, but knowledge is one of the most precious things we'll ever own. Knowledge is not given, it's earned, and there is always more we can learn. So the next time a rep comes around, let her or him in, and with new information, both of you can win."



The author, who prefers anonymity, is a sales representative for a pharmaceutical company in Illinois.

## LETTERS

### No 'back door' abolition of death penalty intended

I would like to make the following points in response to Sen. [Robert M.] Raica's letter in the July 17 issue.

H.B. 3607 as it was passed by the House was clearly not consistent with either the AMA House of Delegates position expressed in December 1991 or the ISMS House of Delegates position expressed in April 1992. The amendment proposed by ISMS at the Judiciary Panel I Committee hearing was sufficient, in that it complied with the ISMS House of Delegates position of April but was not ideal in that the amended bill still failed to exclude physicians from the execution process.

The secrecy provisions of the Code of Criminal Procedure maintained by the original H.B. 3607 as applied to physicians made the efficiency of an execution superior to the self-regulated ethical behavior of physicians as ensured by the Illinois Medical Practice Act. This contradiction between two state laws established a basis for a constitutional challenge between them. I proposed addition of the statement "No physician shall be permitted to participate or perform ancillary functions in an execution."

During questioning, I was asked whether I was personally opposed to the death penalty and (if) my personal involvement in this issue was an attempt to subvert the death penalty. I specifically stated that I do not personally oppose the death penalty in this state but that the ethical injunction against physician participation in executions was clearly an acknowledgment of the role of the physician as healer who could be trusted to "do no harm." To involve physicians in the execution process would obscure the roles of healer and executioner.

I was (also) asked if it was necessary for physicians to pronounce death. I replied that the physician's pronouncement of death in the execution constituted an integral participation in the process: If the prisoner were not pronounced dead during or after an injection, this expressed judgment would be a signal to the executioner to continue or reinitiate the lethal injection. I also pointed out that the majority of violent deaths in this state are pronounced by law enforcement personnel.

There was no effort on my part to "create insurmountable legal problems" to produce a "back door" abolition of the death penalty. In fact, as noted above, I specifically stated during my testimony that I do not oppose the death penalty in this state.

Your comment that the objective of the amendment I proposed was to "go beyond" the ethical position of ISMS is also incorrect. ISMS policy states that it is unethical for physicians to participate in executions "including serving in a witness capacity, medication prescribing capacity or monitoring capacity when pronouncing death after termination of the procedure by the executioner."

Finally, there was concern among members of the medical community that a significant "error" in legislative judgment would be made if H.B. 3607 were adopted without amendment. I attended a fact-finding legislative hearing as a concerned citizen of this state in order to communicate this position. I took care to organize a clean and simple statement abstracted from written testimony, and I distributed pertinent documents supporting the amendment to exclude physicians from the execution. I exercised my "First Amendment right" to address the legislature.

I did not expect your letter to *Illinois Medicine*, with its innuendos and inaccurate comments belittling both myself and a respected ethical position in medicine. Nor did I expect to be targeted personally as a "scapegoat" for the change in your decision to support H.B. 3607.

I am disappointed to find this behavior in someone who has been elected by the citizens of Illinois to a respected public office.

— Ann Marie Dunlap, M.D.  
Homewood

### Senator misconstrued profession's efforts

Sen. Raica's letter [July 17 issue] seriously misconstrued the efforts of the medical profession to get doctors out of the execution chamber. ...

In opposition to the clear ethical standard of the medical profession worldwide, which has been articulated unequivocally by the ISMS, the AMA and the World Medical Association, [Illinois'] Code of Criminal Procedure places a physician in the role of the executioner's helper. Eloquent testimony to this effect has been given by Illinois and other prison physicians. To their everlasting credit, these Illinois prison physicians refuse to participate in any capacity in executions. (Kudos to us – ISMS – for getting the role of physician-as-witness eliminated in the current law!)

Sen. Raica and his colleagues exercised considerable imagination when they saw intentions that weren't there. Certainly the ethical standards of our profession don't need Sen. Raica's "sympathy." However, they do need his respect.

The legislators and the attorney general and staff of the Department of Corrections who "disagree" with the medical profession's code of conduct quite simply have little standing or authority to comment in these matters. Our ethical standards are the autonomous responsibility of our profession to articulate, to enforce and to defend. We must insist that they be respected in law.

— William Gibbons, M.D.  
Elgin



## MEETINGS

## Illinois Psychiatric Society holds fall weekend meeting

[ CHICAGO ] The Illinois Psychiatric Society has scheduled its 1992 Fall Weekend Meeting for Oct. 9-10 at the Stouffer Riviere Hotel in Chicago. The meeting will include four in-depth sessions on the specialty's most pressing issues: psychiatric ethics, managed care rights and appeals, organizational practice as the future of psychiatry, and the importance of psychodynamic training for practitioners.

The meeting will also include presentation of awards and a lecture by Jeremy Lazarus, M.D., chairman of the American Psychiatric Association's Ethics Committee.

The registration fee is \$85 for IPS members and \$125 for nonmembers. For more information, contact the IPS office at (312) 263-7391. ■

## Career Opportunities Day for internal medicine

[ CHICAGO ] Rush-Presbyterian-St. Luke's Medical Center of Chicago is holding a Career Opportunities Day for internal medicine on Saturday, Sept. 19. All internists and subspecialists are encouraged to attend this free event to explore opportunities in a wide variety of practice settings.

The day begins with a program covering entry into a practice, professional liability insurance, practice management and the role of organized medicine. Exhibitors invited include large and small group practices, hospitals and clinics, health plans, solo practices and professional recruitment firms.

Located at Rush-Presbyterian-St. Luke's Medical Center Professional Building in Chicago, the fair runs from 9 a.m. to 2 p.m. For more information, contact the Illinois Society of Internal Medicine at (312) 263-7150. ■

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▲ The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

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Please see references and brief summary on adjacent page.

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### BuSpar<sup>®</sup> (buspirone HCl)

**References:** 1. Data on file, Bristol-Myers Squibb Company. 2. Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clonazepam in anxious outpatients with or without depressive symptoms. *Psychopharmacology* 1992;25:10-21. 3. Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychopharmacology* 1989;21:124-130. 4. Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med* 1987;82(suppl 5A):20-26. 5. Newton RE, Marunycz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med* 1986;80(suppl 3B):17-21.

**Contraindications:** Hypersensitivity to buspirone hydrochloride.

**Warnings:** The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

**Precautions:** **General**—Interference with cognitive and motor performance: Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

**Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients:** Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdrawal patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

**Possible concerns related to buspirone's binding to dopamine receptors:** Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

**Information for Patients**—Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

**Drug Interactions**—Concomitant use with other CNS active drugs should be approached with caution (see Warnings). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

**Pregnancy: Teratogenic Effects**—Pregnancy Category B: Should be used during pregnancy only if clearly needed.

**Nursing Mothers**—Administration to nursing women should be avoided if clinically possible.

**Pediatric Use**—The safety and effectiveness have not been determined in individuals below 18 years of age.

**Use in the Elderly**—No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

**Use in Patients with Impaired Hepatic or Renal Function**—Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

**Adverse Reactions (See also Precautions): Commonly Observed**—The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

**Associated with Discontinuation of Treatment**—The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling, gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

**Incidence in Controlled Clinical Trials**—Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: **Cardiovascular:** Tachycardia/palpitations 1%. **CNS:** Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. **EENT:** Blurred vision 2%. **Gastrointestinal:** Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. **Musculoskeletal:** Musculoskeletal aches/pains 1%. **Neurological:** Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. **Skin:** Skin rash 1%. **Miscellaneous:** Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

**Other Events Observed During the Entire Premarketing Evaluation**—The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. **Cardiovascular**—frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. **Central Nervous System**—frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. **EENT**—frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. **Endocrine**—rare: galactorrhea, thyroid abnormality. **Gastrointestinal**—infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. **Genitourinary**—infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. **Musculoskeletal**—infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. **Neurological**—infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. **Respiratory**—infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. **Sexual Function**—infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. **Skin**—infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. **Clinical Laboratory**—infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. **Miscellaneous**—infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

**Postintroduction Clinical Experience**—Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

**Drug Abuse and Dependence: Controlled Substance Class**—Not a controlled substance. **Physical and Psychological Dependence**—Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

**Overdosage: Signs and Symptoms**—At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

**Recommended Overdosage Treatment**—General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

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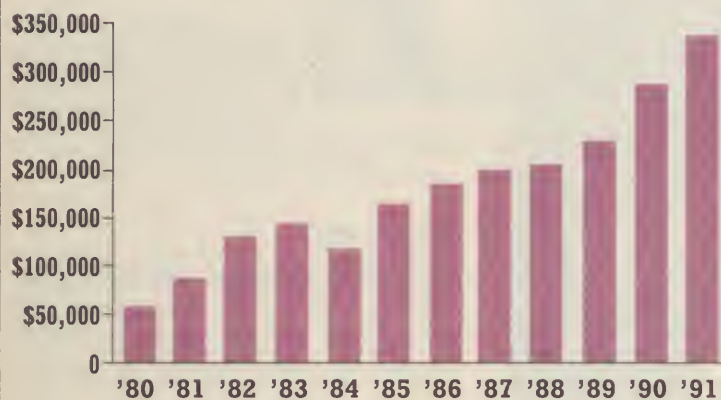
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# ISMIE Update

Case in  
point  
explores  
medication  
errors

PAGE 10

## ISMIE average indemnity payment 1980-1991\*



\*Per claim closed with indemnity. Source: Illinois State Medical Inter-Insurance Exchange.

## Two studies seek to reduce medication errors

**LIABILITY TRENDS:** As medication errors are pinpointed as major factors in malpractice lawsuits, studies are under way to find and reduce their causes. By Anna Brown

[ WESTCHESTER ] Premier Hospitals Alliance Inc. of Westchester and the Physician Insurers Association of America are conducting separate studies on a variety of medication errors in hospitals, doctors' offices and other health care delivery sites. Both studies will attempt to identify trends that could serve as the basis for prevention programs throughout the country.

Premier Hospitals Alliance Inc. received a \$399,978 grant from the Robert Wood Johnson Foundation to conduct its study. The group is a nationwide voluntary cooperative of 49 major teaching and research hospitals. The two-year grant will fund a confidential data base of self-reported medication errors, according to Premier President Alan Weinstein.

The project will begin with a pilot group of five to 10 Premier hospitals, said Robert Katzfey, director of the Medication Error Prevention Initiative, a year-old program of Premier that has worked with the FDA to approach drug manufacturers to correct confusing product

packaging. "In six months we will expand to include 25 to 30 hospitals, and in two years we should be close to 100," Katzfey said, explaining that the organization will first target Premier hospitals.

"We're asking hospitals to tell us specific information about medication errors, such as the name of the drug, the dosage and when and where the error occurred," Katzfey said. "Through a series of questions we can try to identify patterns."

Information from the study will be used to document the extent of drug errors in the study hospitals and project the potential for errors to the hospital industry as a whole; develop specific recommendations on how to reduce errors; develop a prototype for a national reporting system for hospital medication errors; establish guidelines and educational programs for practitioners; and develop an "early warning system" for specific errors.

Katzfey said the study will be strictly voluntary and confidential. Premier was originally

## New programs, publications help physicians avoid medication errors

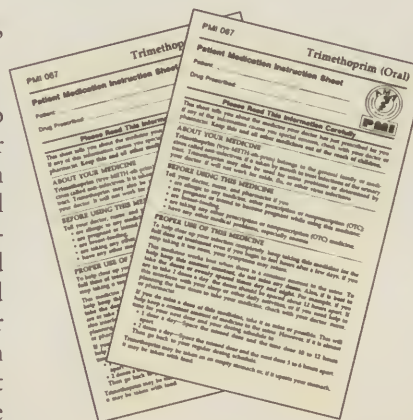
**DRUG ERRORS:** Seminars and patient handouts are available to physicians to help avoid medication-related lawsuits. By Anna Brown

[ CHICAGO ] In early 1993, the Illinois State Medical Inter-Insurance Exchange plans to add a new seminar to its lineup of malpractice stress, cancer diagnosis and documentation seminars. The seminar will focus on the correct use of medications and ways to avoid medication errors that could lead to malpractice claims or lawsuits. Errors range from problems of prescribing without examining the patient to failure to obtain informed consent to confusing drug packaging.

The one-day seminar, sponsored by the Exchange Risk Management Committee, will include a full-day program of case studies and guest speakers.

Topics to be addressed include the reasons behind medication errors, discussions with patients about over-the-counter medications, the legal aspects of using medications beyond the manufacturers' intent, informed consent, and pharmacological implications for high-risk patients, such as children, pregnant women and the elderly.

**FOR PHYSICIANS WHO** can't wait until the spring, the American Medical Association and the



U.S. Pharmacopeial Convention Inc. offer educational materials on drugs for both physicians and patients.

The AMA has been working with the USPC to improve its Patient Medication Instructions program. PMIs are leaflets for physicians to give to patients explaining specific drugs and drug classes. AMA officials say the leaflets are regularly reviewed and updated.

Each PMI provides a description of the medicine and its purpose, guidelines on its proper use and information on side effects — including those that should be reported to the physician and those that do not usually require medical attention.

PMIs are available from the USPC for \$2.25 per pad of 50 sheets. Physicians may order PMIs by sending a check or money order to USPC Order Processing Department 769, 12601 Twinbrook Parkway, Rockville, MD 20852. Phone orders are also accepted at (800) 227-8772. A free AMA Patient Medication Instruction Kit is also available from the same number, extension 769. The kit includes the 1992 USPC catalog with comprehensive drug information, more patient education materials and an index for ordering the AMA PMIs.

**THE AMA ALSO** publishes its *Drug Evaluations Manual* and *Drug Evaluations Subscription*. The 1992 manual, which features labeled and unlabeled uses for newly approved and older drugs, costs \$75. It can be ordered by calling (800) 621-8335 and requesting No. OP025591CH. The subscription — order No. NR000117CH — is similar to the manual, but it includes quarterly update supplements with chapter revisions, a newsletter and a new index. ■

## MALPRACTICE ROUNDUP

### In pursuit of the cause of medication-related lawsuits

The Physician Insurers Association of America recently listed the most common causes of medication error-related lawsuits in its publication, *The Physician Insurer*.

The causes include

- allergic reactions;
- prescriptions for nonsteroidal anti-inflammatory medication for patients who are already taking aspirin;
- reactions to contraindicated medications;
- side effects;
- excessive or incorrect dosages;
- prescriptions for the wrong medication, usually because names or packaging is similar;
- unexpected drug interactions.

The PIAA also called informed consent a "critical step" in the prescribing process, especially when prescribing above the dosage level recommended by the manufacturer or that listed in the *Physicians' Desk Reference*. The group likened the PDR to an "expert witness that is a ready and authoritative tool for plaintiff attorneys to use in medication error lawsuits." ■

(Continued on page 10)



## Exchange to eliminate grace period for premium payment

Every quarter the Illinois State Medical Inter-Insurance Exchange bills for premium payments due on the first of July, October, January and April. Last year, if you hadn't paid by these dates, you would have received a 15-day extension. Over the next two years, that grace period will gradually disappear, until your coverage will be terminated if you have not paid by the first of the month.

This year, the extension was shortened by five days. Policies will be terminated if payments have not been received by Oct. 9; Jan. 11, 1993; and April 9, 1993. There is a 10-day automatic reinstatement period after these dates. After this time, the reinstatement process is more complicated. Extremely late payers whose policies have been canceled are reviewed for reinstatement on an individual basis, taking payment history into consideration.

In other words, don't wait to pay! It's later than you think.

### Exchange 1992-93 policy year billing schedule

Second Quarter	Issue date	Due date
Quarterly invoice	Aug. 10	Oct. 1
Termination notice	Sept. 25	
Cancellation for nonpayment	Oct. 9	
Third Quarter	Issue date	Due date
Quarterly invoice	Nov. 9	Jan. 1, 1993
Termination notice	Dec. 28	
Cancellation for nonpayment	Jan. 11, 1993	
Fourth Quarter	Issue date	Due date
Quarterly invoice	Feb. 8, 1993	April 1, 1993
Termination notice	March 26, 1993	
Cancellation for nonpayment	April 9, 1993	

## Two studies

(Continued from page 9)

approached by its member hospitals, which were concerned about providing the best possible care and eliminating liability. Error reporters could be anyone in the institution, he said, from physicians to nurses to risk managers.

The first phase of the study, targeting only Premier hospitals, will conclude in July 1994. The second phase, which will incorporate institutions outside of Premier, will begin in 1994-95.

**THE PIAA'S STUDY**, begun by its Data Sharing Committee, seeks to identify areas of risk in order to reduce medication error

lawsuits. The group will draw information from its data base of more than 78,000 malpractice claims and lawsuits. The Data Sharing Committee is also soliciting information from the PIAA's 44 member companies to help identify trends in malpractice suits stemming from medication errors.

The medication error study is the PIAA's fifth major study to make use of the data base. Previous study topics included neurologically impaired infants, and breast, colon and lung cancer. The current study is expected to be completed by November, and final results will be announced at the organization's June 1993 annual meeting. ■

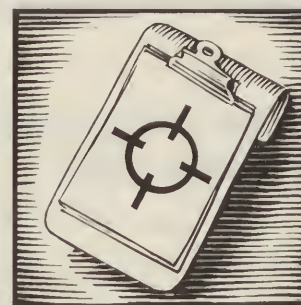
## Case in Point

*A regular feature using hypothetical case histories to illustrate loss prevention maxims.*

By Carol Brierly Golin

### Case #1

**Presenting complaint and initial diagnosis** – A 75-year-old woman with medication-controlled hypertension went to a hospital emergency room complaining of fatigue and shortness of breath. Mild congestive heart failure was diagnosed, and furosemide was prescribed.



**The case in brief** – The patient was advised to return to the hospital outpatient clinic in a few days for a follow-up visit. When she did, she was feeling well. Nevertheless, the hospital physicians suggested that she be hospitalized for observation and a possible medication change. She agreed and was placed on quinidine under the care of an internist who had not seen her before. One day after starting on the drug the woman complained of fatigue, diarrhea, heartburn and nausea. The internist examined her, but did not suspect quinidine poisoning. She died the next day.

**The resulting claim** – The woman's family sued for wrongful death, negligence in failing to diagnose the drug reaction and failure to properly treat it.

**The outcome of the claim** – The case was settled for \$375,000.

### Case #2

**Presenting complaint and initial diagnosis** – A 41-year-old man suffered injuries in a fall. His family doctor pre-

scribed cyclobenzaprine hydrochloride, a muscle relaxant.

**The case in brief** – A few days later, the man went to a hospital emergency room suffering from hallucinations. ER physicians treated him for a possible drug reaction. Eventually he was hospitalized, and two days later, he died.

**The resulting claim** – The patient's wife sued for failure to diagnose and properly treat his reaction to the drug and for failure to properly monitor him. However, the man was an alcoholic whose death may have been related to alcoholism, not to the drug. The admitting physician took a history, but the extent of the patient's alcohol use had not been brought out.

**The outcome of the claim** – The defendant offered \$300,000 to settle the case, but the plaintiffs declined. The case went to trial, and a jury found the defendant not guilty.

### Case #3

**Presenting complaint and initial diagnosis** – A 64-year-old man with Parkinson's disease and knee problems investigated the possibility of surgery.

**The case in brief** – His neurologist advised against surgery because of the Parkinson's, but the man went ahead with the operation. The neurologist left standing instructions that he be consulted if any Parkinson's-related developments occurred. After the successful operation, the patient began to hallucinate, and the treating internist prescribed chlordiazepoxide hydrochloride. The neurologist was not consulted. The patient began to aspirate food, and his condition deteriorated rapidly during the next few weeks.

**The resulting claim** – The patient and his wife sued the internist and the hospital for negligence in giving him chlordiazepoxide hydrochloride in the presence of his Parkinson's and for not heeding the neurologist's instructions.

**The outcome of the claim** – The defense argued that the patient's reactions were a result of his disease and the withdrawal of his regular medicine in anticipation of surgery. However, a jury found both the internist and the hospital liable for \$400,000.

**The points these cases make** – In each of these cases liability arose because physicians either failed to take adequate, detailed medical histories or did not obtain information from histories taken by other physicians, said Vasanth Surath, M.D., incoming president of the Illinois Society of Internal Medicine and a member of the Illinois State Medical Inter-Insurance Exchange Risk Management Committee.

"In the first case, the patient suffered a severe reaction to a new medication," Dr. Surath explained. "The new physician apparently assumed that the patient had been taking quinidine for some time and did not recognize the reaction. If an individual suffers a reaction to quinidine it typically will occur in the first 24 to 48 hours and it will be critical. Because

## The PBT Challenge

Look For Solution In This Issue!

### ACROSS

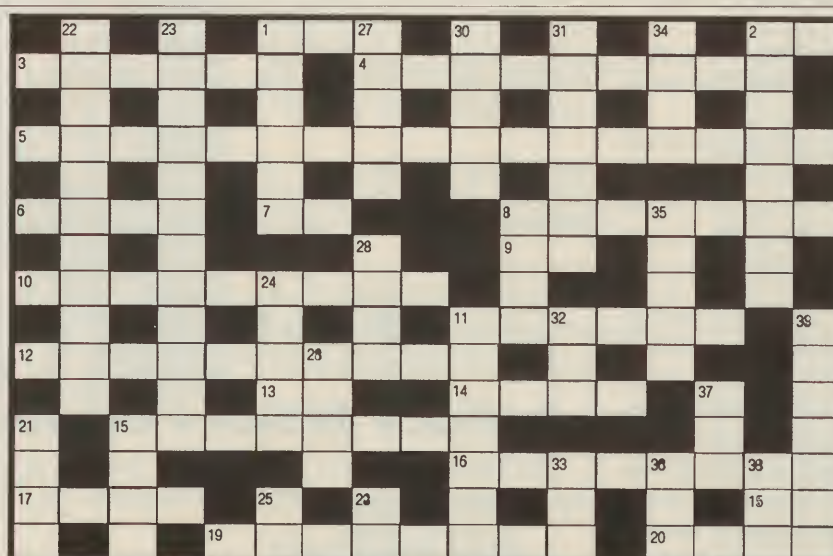
- Natural juice of a living organism or tissue
- Obstetrics (abbrev.)
- Mutant gene that has no effect on its substrate; an inactive gene
- German physician associated with the saccharimeter
- Often required by insurance companies before a hospital stay (hyphenated word)
- Small piece
- Developmental Age (abbrev.)
- Homeopathic preparation of silica
- Mental age (abbrev.)
- Liver disease
- Genus of spider
- Pericarp and germ of grains which are removed

in processing

- Holmium (abbrev.)
- Thin side or border
- Excess in the number of parts
- Maintenance of a relatively constant body fluid volume and composition
- Outer integument or covering of the body
- Astatine (abbrev.)
- Congenital absence of one or both lips
- Skin lesion.

### DOWN

- Watch glass fitted over the eye to guard against gonorrheal or ophthalmic infection
- Development of the individual organism
- Disease of cereal grasses caused by basidiomycetous fungi



- Pertaining to the skin
- Localized sensation of discomfort
- Organ of smell
- Inflammation of the shoulder joint
- Often required by insurance companies before surgery but never by the PBT (Hyphenated word)
- Combining form denoting relationship to serum
- Before meals (Latin abbrev.)
- Unit of loudness
- Flat structure or layer
- Not in good health
- Helium (abbrev.)
- To irritate the skin
- Congenital absence of the sacrum
- Electrocardiogram
- Female reproductive cells
- Fragment of embryonic

- tissue retained within the adult organism
- Discharge of pus, blood, or other matter
- Scrapings or filings (Latin abbrev.)
- Mixed astigmatism with myopia
- Auris
- Salt of sulfuric acid

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the physician lacked a valuable piece of information, the patient died."

When patient care is shared among several physicians, the possibility increases that critical data will not be conveyed, the internist said. This is particularly true in group practices in which one physician may see all hospitalized patients on a given day, another physician sees them on the next, and so on.

"Consequently, if a physician is seeing a patient for the first time, it is very important to take an additional history, as well as to obtain and review the previous history and notes from the treating physician," said Dr. Surath. "This information must include which medications the patient is taking and for how long, so that the physician will be alert to the possibility of a drug reaction."

In the second case, said Dr. Surath, alcohol augmented the effects of the muscle relaxant and the man eventually died.

"I want to emphasize that in taking a history it is extremely important to determine details about alcohol use, frequency, amounts and the length of time that the individual has been drinking," he said.

Although physicians sometimes are reluctant to question patients about alcohol use, new medical knowledge has shown that alcohol can significantly augment or decrease the effect of various medications, he said. Such information may also reveal an addiction.

"When prescribing a medication, a physician must assume that a patient is on two drugs if it is determined he or she uses alcohol. Patients should be warned not to drink when taking certain medications," Dr. Surath said.

The third case demonstrates a critical lack of communication among consultants, he said. "This can happen, particularly with the number of elderly patients today who are hospitalized with multisystem illnesses or ailments. The record becomes massive, and it is tedious and time-consuming to keep track of every consultation."

The primary physician and the consultants should make extra efforts to share information about a patient – by telephone, by personal contact and by carefully placing relevant data in the chart and referring to the chart regularly, he suggested. Review should be ongoing, and the primary physician should read the chart daily to look at consultants' recommendations and carry them out.

Dr. Surath suggested following these steps:

- Take a complete history for every new patient. The history should include information about medication, and alcohol and drug use.
- Take an additional history if you are a covering physician seeing the patient for the first time.
- Pay attention to details in the hospital medical record, including nursing notes. Do not overlook consultant recommendations. The primary physician should review the chart and all consultant recommendations daily to make sure follow-through occurs.
- Be alert to possible drug reactions if changing medications or adding others.
- Consider alcohol a "second drug" when prescribing any medication and consider the synergistic/antagonistic effects.
- Place updates to a patient's chart in the appropriate place so that other physi-

cians or hospital personnel will not miss them.

"In spite of great medical technological advances, taking a complete patient history is still the first step to arriving at a correct diagnosis," Dr. Surath said.

Also, medical liability exposure is the same regardless of whether a physician is in charge of a patient for a year or a single office or hospital encounter. Complete, detailed histories reduce this liability but only when the data in the history and the chart are routinely reviewed and there is appropriate follow-up. ■

*Carol Brierly Golin is publisher of Medical Liability Monitor.*

## EXCHANGE Q & A

**Q: I am a "Class 2" physician. Will my rating classification change if I assist in surgery on my own patients only or if I also assist on other cases?**

**A:** Your rating will remain the same whichever option you choose. Assisting in surgery is rated as a "minor risk" procedure. It requires a minimum class rating of "2" for physicians with a nominal specialty classification of "0" or "1."

**Q: What changes in my practice should I report to the Exchange?**

**A:** Only the named insured can authorize a policy change. Reportable changes might include practice relationships or location and hospital affiliation. ISMIE should be notified before any changes are made. A "change request form" can be obtained from the policyholder relations department or Underwriting Division.

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# Key contests to watch in the 1992 general election



**ELECTION COVERAGE:** *Illinois Medicine* queried candidates for the U.S. Senate and selected congressional seats on their positions regarding health care reform and tort reform. Following are some of their responses. By Kevin O'Brien

2<sup>nd</sup>  
DISTRICT

**Ron Blackstone – Republican**

Ron Blackstone of Homewood, a former police officer, is currently serving a third term as a member of the Homewood-Flossmoor High School Board. He is president of RJB Properties Inc., which employs more than 140 people, and was a regional sales manager in Chicago and Washington, D.C., for R.R. Donnelley. He attended Knoxville College in Knoxville, Tenn., on a basketball scholarship, obtaining a bachelor's degree in political science and sociology. He earned an MBA from the University of Chicago's Executive Program.

Blackstone supports modifying the current health care system instead of enacting a universal health care plan. "Those currently denied [access] must have insurance available to them through the use of community rating or risk pools," he said. "Universal health care plans such as [those] in Canada, Germany and other countries will only become a mammoth, expanding, expensive bureaucracy in the United States. By modifying our current system to develop a plan that provides health care access for all, we can continue to have quality care that permits choice."

The Republican candidate in the 2nd Congressional District also supports caps on noneconomic damages. "Changes must be made in the legal system in handling malpractice cases. ... Individuals who have been injured in medical malpractice situations should receive adequate [compensation] for actual economic damages. However, a cap needs to be placed on awards for pain and suffering. No longer can our medical system sustain such awards as that of \$100 million to a senior citizen for the loss of one eye."

Blackstone also favors incentives for preventive care and streamlining paperwork. He supports the concept of a universal claim form and increased use of electronic claims processing.

**Mel Reynolds – Democrat**

Despite repeated requests, Reynolds' campaign failed to furnish information on the candidate's views on health care.

8<sup>th</sup>  
DISTRICT

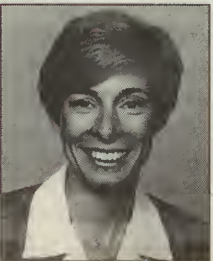


**Philip M. Crane (I) – Republican**

U.S. Rep. Philip M. Crane of Mt. Prospect currently represents the 12th Congressional District but is seeking re-election in the new 8th Congressional District. First elected in 1968, Crane, who lists his profession as an American history professor, sits on the powerful Ways and Means Committee and is the ranking minority member of its Subcommittee on Trade.

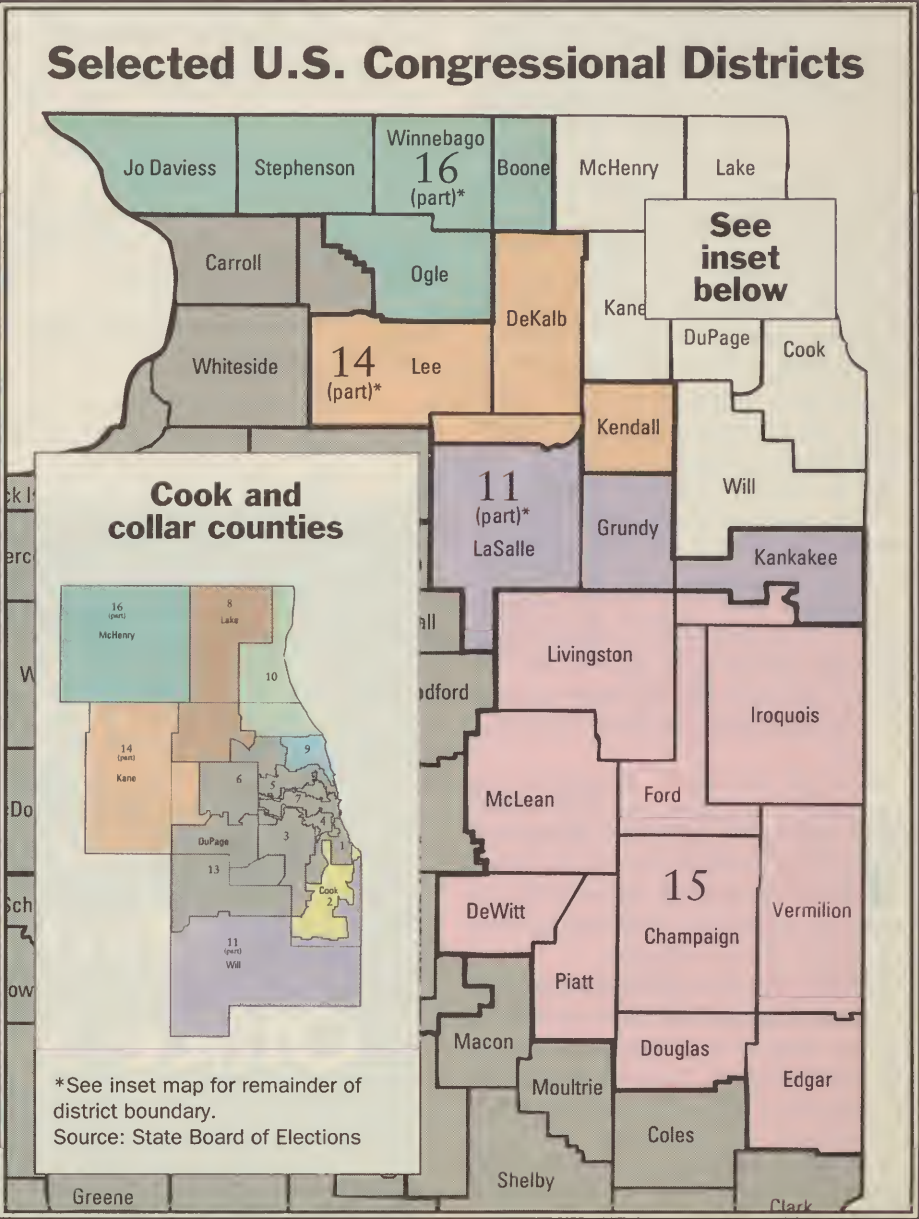
Crane opposes a national health care insurance plan. "If we put the federal government in charge of health care, each of us will be subject to a heavy additional tax that is levied with no consideration of whether we will be using the system." Instead, Crane calls for tax credits to individuals to increase access. "Tax incentives, as opposed to government programs, will allow for individual choice within the context of a free market system."

He would establish a Health Care Savings Account to permit individuals to set up voluntary, tax-favored personal savings accounts to meet health care needs in retirement. He also favors individual tax credits for health care premiums and penalty-free withdrawals from IRAs to cover health care costs. He supports tort reform, including caps on noneconomic damages, although he prefers that the states – not the federal government – enact such reforms.



**Sheila Smith – Democrat**

Challenging U.S. Rep. Philip M. Crane in the new 8th Congressional District is Galena businesswoman Sheila Smith. Born and raised in Chicago, Smith received a bachelor's degree in political science from Barat College in 1970 and a master's degree from the University of Illinois at Chicago in 1971. Her 20-year business career includes a stint as a manage-



ment consultant specializing in mergers and acquisitions. In 1981, she purchased Glowlite Sales Ltd., which was in danger of closing. She said the company became profitable, with \$65 million in annual sales and 115 employees in its Oklahoma plant and offices in Illinois, North Carolina and Taiwan.

Smith supports a public/private health care system designed to encourage employer-based health insurance. She favors state or federally imposed limits on the percentage increases of insurance premiums, adoption of community ratings by insurance companies, elimination of pre-existing conditions as a basis of refusing insurance, patient fees "for each instance of care," and federal monitoring of quality control standards.

Smith's campaign was unable to provide information regarding the candidate's views on tort reform.

9<sup>th</sup>  
DISTRICT



**Herbert Sohn, M.D. – Republican**

Chicagoan Herbert Sohn, M.D., possesses an admirable quality in abundance – persistence. For the fifth time, Dr. Sohn takes on a legislative legend as he mounts another challenge to 44-year-incumbent U.S. Rep. Sidney R. Yates.

"All the work has been done," the always upbeat Dr. Sohn told *Illinois Medicine*. Noting the national plethora of health care reform proposals, he said, "I think that what we need right now is someone in Congress who has the experience to lead the debate, to sit down and get people together. ... And what I want to do is bring everyone together to sit down at the table and get a plan. [The plan] may not be good for everyone, but I want something that will be perceived as fair to everyone."

Although Dr. Sohn said he is "strictly opposed to socialized medicine," his most important priority is to solve the access problem for the estimated 37 million people who are currently uninsured. "You measure civilization by the amount of care you give the people who can't take care of themselves – the handicapped, the poor. If we want to be a civilized society, we have to take care of these people; they have to be a priority."

Dr. Sohn has long been on record as supporting caps on noneconomic



## United States Senate



### Richard S. Williamson – Republican

Richard S. Williamson of Kenilworth is an attorney and former aide in the Reagan White House. Initially not given much of a chance against incumbent Sen. Alan Dixon, Williamson's candidacy acquired viability overnight when Carol Moseley Braun defeated Dixon and trial lawyer Al Hofeld in the Democratic primary. Since then, Williamson has worked to increase his name recognition, especially in southern Illinois, where conservative Democrats who favored Dixon might be persuaded to desert Braun. Williamson's campaign got a boost during the Republican National Convention in Houston, as he maximized his visibility with Illinois media covering the convention.

"I reject radical proposals such as the Canadian health care system – a proposal embraced by my opponent – that would result in costs soaring at an even faster pace than we now experience," Williamson said in a statement for *Illinois Medicine*. Instead, Williamson supports a "health care system that will be open to all people, affordable, and at the same time, [will] preserve free choice for the patient."

Williamson would create risk pools within the current insurance system to permit coverage for temporarily uninsured people during the period between jobs. For the "chronically uninsurable," he advocates a voucher system redeemable with private insurers in permanent risk pools that spread the cost burden. To better contain costs, Williamson calls for "meaningful" administrative reform. "For every dollar of health care costs, as much as 25 cents goes to paperwork and administrative costs," he said.

To attain such reform, Williamson would introduce a universal health card similar to that used in many European countries. "It is estimated that the card will cut paperwork costs by over 85 percent, for a savings to the health care system of over

\$50 billion per year."

Williamson also supports "medical malpractice reform to curb unjustified lawsuits, and broader application of alternative dispute resolution mechanisms." He calls increased prevention efforts a vital component of reform and said he supports "expanded research to fight cancer, heart illness and other killer diseases."



### Carol Moseley Braun – Democrat

Carol Moseley Braun's campaign did not return several telephone calls seeking information on the candidate's views on health care. Braun, who scored an upset primary victory over veteran incumbent Sen. Alan Dixon and trial attorney Al Hofeld, is on record as supporting the single-payer, government-run plan proposed by U.S. Rep. Marty Russo of Illinois.

Braun told *MCHC Update*, the publication of the Metropolitan Chicago Healthcare Council, "This single-payer system would eliminate the lion's share of the \$70 billion in administrative costs that Americans paid during 1991 and bring accessible health care to all Americans."

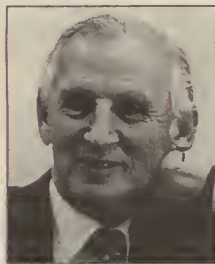
"Over and above the savings that would be realized by the administrative consolidation of a single-payer system," Braun continued, "hospitals would be paid according to annual negotiated budgets and independent practitioners according to negotiated fee schedules."

In addition, Braun said the system would be funded "through a combination of taxes and savings gained through administrative savings. Funds would flow through a National Health Trust fund that would be financed through taxes on corporations and the upper taxpayer echelons."

## 9th DISTRICT

damages in medical malpractice cases. "I think that we've got to resolve this problem. We can no longer afford these unreal judgments in medical malpractice. We [physicians] have done our job. We have spent a lot of time teaching people to practice well so we can cut [malpractice suits] down."

Also a lawyer, Dr. Sohn is vice chairman of the Health Care Council of the Illinois State Bar Association. He touts the advantages he derives from his dual professions and maintains that his extensive experience working with physicians, lawyers and others suits him well in his mission to "bring everyone together."

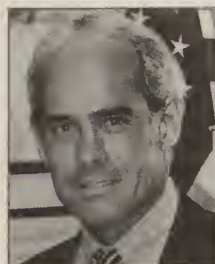


### Sidney R. Yates (I) – Democrat

Sidney R. Yates, 83, has been the 9th Congressional District representative since 1949. He chairs the Interior and Related Agencies Subcommittee, which oversees appropriations for the National Endowments for the Arts and Humanities. His office provided the following written statement:

On health care reform – "There are a number of health care initiatives that have been introduced into the 102nd Congress. The Universal Health Care Act of 1991 (H.R. 1300), introduced by Congressman [Marty] Russo, is one of the most promising in my opinion. I am an original co-sponsor of this bill. In debating this issue further, we will all need to come together on the most efficient and cost-effective approach in order to provide affordable health care for all Americans."

On tort reform – "I oppose most recent efforts to 'reform' tort procedures. Capping punitive damages in product liability cases benefits corporations guilty of egregious wrongdoing. Making losers of civil suits pay the lawyer fees of the opposing side will discourage the average citizen from filing justifiable cases. I will support real tort reform that makes the legal system more accessible, not more restrictive."



### John Porter (I) – Republican

A 12-year veteran of Congress, U.S. Rep. John E. Porter of Wilmette serves on the Appropriations Committee and the Select Committee on Aging. He has been active in recent congressional attempts to resolve the controversy surrounding the federal "gag rule" prohibiting abortion counseling in federally funded clinics.

Porter favors a health care system that guarantees universal access and consumer choice. "For solutions to our health care needs we should rely on the principles that have always worked for America and given us the highest quality services at the lowest possible cost – competition and good old free enterprise," he said.

Porter suggests "empowering all Americans with a certificate of value each year, with which they would buy complete coverage from competing health care benefit plans. Everyone would be covered, including the urban poor, rural residents and currently uninsured Americans, and no

## 10th DISTRICT

one, regardless of prior health history, could be refused by any plan."

He envisions plan organizers to be insurance companies, physician groups or hospital groups, and "all arrangements among insurers – hospitals, physicians, clinics, labs, home health care units and other providers – would be in the private sector and outside of government control."

Porter said the government's role should be limited to providing the certificate of value, establishing the basic coverages that every plan would include and overseeing the system. Finally, Porter said effective risk management and limiting unnecessary defensive medical procedures are important components of any health reform plan. Porter co-sponsored President Bush's tort reform package. The bill pressures states to enact a \$250,000 cap on noneconomic damages and to institute alternative dispute resolutions as an alternative to the current adversarial trial system.



### Michael J. Kennedy – Democrat

Michael J. Kennedy, 27, is making his first foray into elective politics as he challenges Porter in the 10th Congressional District. He received his law degree from the University of Chicago and studied international relations at the London School of Economics, where he earned a master's degree in 1991. Since returning from London, he has worked as a corporate litigator in the firm of Novack & Macey

in Chicago.

There are no "quick fixes" to our health care crisis, Kennedy said in an interview, because many of the current proposals "fail to recognize how intertwined the health care industry is with so many other jobs in so many other aspects of our economy." He said most of the major proposals he has studied fail to deal adequately with the issues he deems most important: access, cost containment and quality control.

"National health care only takes care of one component – access – but I think it does a disservice to cost containment and quality," he said. "The same bureaucracy that pays \$500 for a wrench is not the best [entity] to manage the health care industry or to make it more cost-effective."

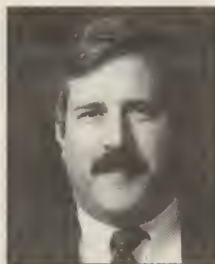
Kennedy said he sees a role for government "to help put the market forces back into medicine," but he is still developing a health care plan that addresses cost containment and quality control, as well as access.

He said he favors tort reform and "would seriously look toward supporting" a cap on noneconomic damages, so long as patients are protected from willful negligence. "In theory, I do support some form of cap ... but there should also be a corollary decrease in the prices that doctors charge."

*Illinois Medicine* will cover key races for the Illinois Senate and House of Representatives in upcoming issues.

## 10th DISTRICT



11  
th  
DISTRICT**Robert T. Herbolsheimer – Republican**

Robert T. Herbolsheimer of New Lenox is a 38-year-old, fourth-generation native of LaSalle County. A partner in the law firm of Manatt, Phelps, Phillips & Kantor since 1988, Herbolsheimer served in the U.S. Environmental Protection Agency from 1980-1985 and was special assistant to EPA Administrator William Ruckelshaus.

Herbolsheimer, who favors caps on noneconomic damages in malpractice cases, has endorsed the Republican-sponsored "Action Now Health Care Reform Act of 1992," that Illinois Reps. J. Dennis Hastert and Thomas W. Ewing co-sponsored. Herbolsheimer also supports President Bush's health policy initiatives. "I am particularly pleased with measures relating to pre-existing conditions that will eliminate 'job-lock' fears and will improve access for those not currently covered," he said. "Congress should reinstate full deductibility of insurance for sole proprietorships, and we may need to develop risk pool approaches, either private or public, or tax credits that would enable small businesses to provide insurance for their employees.

"With regard to controlling costs," Herbolsheimer continued, "I am particularly interested in the creative approach outlined recently by Congressman Hastert, which would establish a medical savings account for employees covered under a group health plan." Under this approach, he said, a plan currently costing an employer \$4,500 in premiums with a \$200 deductible would be changed to a \$3,000 deductible. The \$3,000 would be placed in an employee "MediSave" savings account that could be tapped to satisfy the deductible. Whatever was left in the account at the end of a given year would go to the employee to be used for health related matters or retirement.

"This approach would save insurance companies and customers substantial sums, because it eliminates many administrative costs," he said. "In addition, it would allow individuals to make a choice about their health care, recognizing that the money they save is their own."

**George E. Sangmeister (I) – Democrat**

U.S. Rep. George E. Sangmeister of Mokena hopes to return to Washington as the representative of the new 11th Congressional District.

"I believe that health care is a right – not a privilege – and all Americans deserve access to quality care regardless of their ability to pay," Sangmeister said in a statement for *Illinois Medicine*. Originally

a co-sponsor of the universal health care measure introduced by U.S. Rep. Marty Russo of Illinois, he has since backed away from that bill because Russo will not be returning to Congress.

Sangmeister said he favors a single-payer plan to provide universal coverage, including long-term care, mental health services and prescription drug services; allowing Americans to choose their own physicians and other providers; and financing by a partnership of the federal government, business and beneficiaries. Criticizing the time-consuming paperwork resulting from more than 1,500 health care plans in the current system, he said, "It is not surprising that administrative costs consume 11 percent of private health insurance expenditures." He contrasted that with Medicare, which, he said, "spends only 2 percent on administrative costs."

Sangmeister said he favors medical malpractice reform, but a spokesman said he was undecided about caps and would evaluate individual proposals.

**J. Dennis Hastert (I) – Republican**

J. Dennis Hastert of Yorkville has represented Illinois' 14th Congressional District since 1987. He earned his bachelor's degree at Wheaton College and his master's degree from Northern Illinois University. He is currently assigned to the Committee on Government Operations, the Select Committee on Hunger and the Committee on Energy and Commerce. He sits on the latter's influential Health and the Environment Subcommittee.

Hastert supports reforms in five key areas, including caps on noneconomic damages. His position is incorporated in the Republican "Action Now Health Care Reform Act of 1992," which was introduced June 4. (See story, page 1.) As a member of the Republican Leader's Task Force on Health, Hastert helped draft the legislation and is a principal sponsor.

"I do not believe a government-run health care system is the right answer for the United States," said Hastert. "While such a system would solve the access problem – everyone would be 'insured' automatically – it has some serious flaws. In 1992, it is estimated that we will spend more than \$800 billion per year on health care. That is three times more than the Pentagon budget, three times bigger than Social Security and seven

14  
th  
DISTRICT**Jonathan Abram Reich – Democrat**

Jonathan Abram Reich, a Unitarian minister, has spent most of his adult life in some form of community service. After working in religious community relations in Chicago, he entered the seminary in 1977. Called in 1982 to the ministry of the Unitarian Society Los Angeles West in California, Reich also taught elementary public school in the inner city for two years. When his wife was offered a faculty position at Northern Illinois University, they moved to DeKalb in the summer of 1988. He has since been a "househusband" and has campaigned saying that a "househusband's place is in the House!"

"Preventive medicine is the real key to reducing our health care costs, far more important than any other reform," said Reich. "If we look at what people are eating and we get doctors to encourage people to look at their habits of sleep and work and how they handle stress, and to cut down on smoking and all these other things, we'll have a healthier population, which will mean a lot less emergency and expensive medical care."

Reich, 45, said he favors a reform plan similar to U.S. Rep. Marty Russo's universal health care proposal to either of the plans advanced by the two major presidential candidates. "I think [Arkansas Gov. Bill] Clinton's plan is superior to [President] Bush's, but I don't think it goes far enough," he said.

Reich says that private insurance companies "have had their chance and they've blown it; they've just blown it. What we've learned from this long experiment with providing health care is that [our] system doesn't work nearly as well as the system does in many other developed countries. There's no reason for America to have a health care system that's third or 10th or 12th or 25th best. We can have a health care system that's the best in the world, but we have to work toward it."

Eliminating the excessive cost that private insurers add should sit well with physicians, Reich said. "There isn't any reason why doctors should oppose this; they're not going to lose out. It's the citizens who are losing, and that means everybody in the country, because it adds enormously to our tax base."

Reich favors limits on awards in medical malpractice suits, although he is not prepared to commit to a specific amount. "That tends to make lawyers unhappy," he said, "but I think we need to find a compromise between what the doctors want and what the lawyers want."

**Thomas W. Ewing (I) – Republican**

Rep. Thomas W. Ewing of Pontiac was elected to Congress in July 1991 to finish the unexpired term of former U.S. Rep. Edward Madigan, who President Bush appointed secretary of Agriculture. During his 17 years in the Illinois House of Representatives, Ewing served as assistant minority leader from 1982-1990 and deputy minority leader in 1990. His congressional committee assignments include Agriculture and Public Works and Transportation.

Ewing is a co-sponsor of the "Action Now Health Care Reform Act of 1992," the congressional Republicans' health care reform plan. Calling the legislation the result of the Republican Leader's Task Force on Health, Ewing said, "These are important first steps in health care reform and should be enacted now. They will lower health care costs and also allow more people – in central and east central Illinois and throughout America – to obtain adequate health care."

"Congress can, if it has the collective political will," Ewing continued, "take action that would make health insurance available for the working uninsured, increase access to health care for the underinsured, and put the brakes on skyrocketing costs. At the same time, Congress can undertake these reforms in a way that preserves and enhances values such as freedom of choice, quality, and availability of care ... without involving major increases in federal expenditures or more bureaucracy and red tape."

Ewing has a long record of supporting caps on noneconomic damages and was the chief sponsor of the 1985 package of tort reform measures in the Illinois General Assembly.

**Charles D. Mattis – Democrat**

Charles D. Mattis, a grade school teacher in Oakwood, is not easy to reach. *Illinois Medicine* managed to catch up with him at his home in Danville during his noon hour, and he consented to a short interview.

Explaining that he was still studying the issue of health care reform,

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Mattis still took issue with what he said was the Democrats' central theme. "My party says we need a national health care system, but I do not wholeheartedly support all of that. There may be ways to keep the present system and provide insurance through government subsidy for those who need it."

On the issue of tort reform, Mattis sought clarification on what caps on noneconomic damages would do. Told that the objective was to control extremely high judgments in such cases, Mattis said he could support caps. "Physicians need to be protected from unreasonable judgments."

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**Donald Manzullo – Republican**

Donald Manzullo, a Rockford native, has practiced law since 1970. He attended American University of Government and Public Administration in Washington, D.C., earning a bachelor's degree in political science and international relations. Manzullo, 48, received his J.D. degree from Marquette University in Milwaukee and has been active in Republican politics since his undergraduate days. He worked for

the U.S. House of Representatives from 1964-67 and is the author of a book and several articles on constitutional law.

"One of the most important things that's going to happen in the next United States Congress is the determination as to whether you are going to be private entrepreneurs or government employees," Manzullo told physicians during an Aug. 24 meeting of the Winnebago County Medical Society.

"I believe that the best way to resolve the health care crisis is not to scrap the private system in favor of a Canadian system or a German system or any other system," Manzullo said, "but to work to reform the best system of medical provision that this world has. And that is to ensure that physicians maintain the right and integrity to be called private entrepreneurs."

Manzullo supports a tax code change to permit 100-percent income tax deductions for self-employed individuals to purchase insurance; the "MediSave" savings plan embodied in the congressional Republican-supported health care reform plan; earned income credits to help individuals making less than \$21,000 with dependents to purchase insurance; tax credits for physicians for equipment purchases; and physicians' deduction of a percentage of their gross income attributed to overhead for medical procedures when caring for the indigent.

Manzullo also favors a "flexible" cap on noneconomic damages in medical malpractice cases, so that allowances are made for higher awards for more seriously injured individuals.

"I have seen the horror of physicians being sued, with the infamous yellow summons being delivered to your doorstep for something that you did, or failed to do, or could have done, whatever the standard is now," said Manzullo.



**John W. Cox Jr. (I) – Democrat**

U.S. Rep. John W. Cox Jr. of Galena won election two years ago to the seat vacated by Secretary of Labor Lynn Martin when she unsuccessfully challenged incumbent Sen. Paul Simon. Cox, 45, was state's attorney for Jo Daviess County from 1970-1985. He graduated from the University of Wisconsin at Platteville and received his J.D. degree from John Marshall Law School in Chicago. He sits on

the Banking, Finance and Urban Affairs Committee and the Government Operations Committee.

During an Aug. 24 meeting of the Winnebago County Medical Society, Cox said he supports a health care reform proposal developed by the Conservative Democratic Forum, which comprises mostly southern Democrat members of Congress. Three CDF members – U.S. Reps. Jim Cooper of Tennessee, Mike Andrews of Texas and Charlie Stenholm of Texas – initiated the proposal.

A key element of the plan is formation of accountable health plans, which sponsors say are improved and expanded versions of HMOs. Under the proposal, all individuals would join state-chartered, not-for-profit umbrella organizations that would buy insurance from the AHPs, which would be required to offer federally defined, uniform health benefit packages that stressed preventive care. Large businesses could negotiate coverage for their employees directly with an AHP. The federal government would pay premiums for low-income people with funds partially provided by repeal of the current Medicaid program.

Cox also used the forum to announce his reversal on the issue of caps on noneconomic damages. "[The CDF] proposal would make substantial changes in the law, including noneconomic damages and reducing unreasonably long statutes of limitations."

Cox did not specify a cap amount, but CDF figures subsequently provided by his office revealed the recommendation of a \$250,000 cap. Cox's press spokesman confirmed that the candidate supports that level.

## What district are you in?

Redistricting has changed congressional, legislative and representative boundaries, and in many cases, voters do not know which district they are now in.

For registered voters, the best way to find out may be to look at your *new* voter registration cards. Most counties and other local voting authorities have mailed voters new cards listing the new congressional, legislative and representative districts. State Senate candidates run in legislative districts and candidates for the Illinois House run in representative districts.

If you live in one of the following nine Illinois communities – Aurora, Bloomington, Chicago, Danville, East St. Louis, Galesburg, Peoria, Rockford or Springfield – call the municipal board of elections there. Physicians who still cannot determine their district can call the Illinois State Medical Society Governmental Affairs Division at (312) 782-1654 or (800) 782-ISMS. ■

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

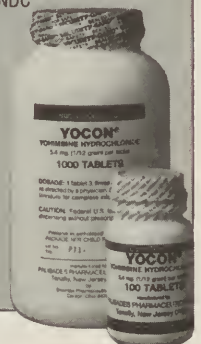
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

**References:**

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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## ISMS SURVEY

# Cost, effectiveness key to prescribing habits

*Physicians consider many factors when choosing prescriptions for patients*

BY JANICE ROSENBERG

**P**hysicians agree: Their No. 1 consideration in prescribing medicines is effectiveness. Physicians tend to treat the same conditions with a fair degree of regularity, and over time they become familiar with the drugs that work best for specific conditions. "When I write a prescription, I think about what's effective and what isn't for the problem I'm treating," said Jay E. Berkelhamer, M.D., a pediatrician in Chicago.

Cost is a second consideration. "I try to find something less expensive," said Jay L. Daskal, M.D., a Chicago obstetrician/gynecologist. "But there are certain circumstances in which only one drug is available for a specific condition."

Doctors sometimes prescribe generic medicines to help patients save money. "When I think it's appropriate or safe, I prescribe generics," said Craig A. Backs, M.D., an internist in Springfield. "That's about 75-80 percent of the time."

But generics aren't always appropriate. "I have no problem with generic antibiotics, but I will not prescribe generic forms of any kind of hormonal preparation, including birth control pills," Dr. Daskal said. "I'm concerned about the biologic activity of these drugs, which is incredibly important for their function. I've had several examples in my practice where generics did not work the same way."

Every drug has side effects that influence physicians' choices. "All the anti-depressants work equally well, but each has different side effects," said Richard K. Baer, M.D., a Chicago psychiatrist. "I try to prescribe one that has side effects that are most useful to the patient. If I have a patient who has trouble sleeping, I choose an anti-depressant that has drowsiness as a

side effect."

As a pediatrician, Dr. Berkelhamer considers whether the drug he prescribes might cause gastrointestinal symptoms. "And I need to know if the child is prone to allergic problems and whether she's had an allergic reaction to drugs like this one," he said.

Because many patients are taking more than one medication, physicians also consider how they may interact. "The pharmacy department at my hospital has a good service on drug-drug interactions," said Patrick R. Staunton, M.D., chairman of the department of psychiatry at Lutheran General Hospital in Park Ridge. "The AMA drug evaluation and PDR do some good work on this, but they don't have as good information as they might in all cases."

Compliance is an issue with all patients - will they take the medication as prescribed? "Convenience is important," said H. Garry Gardner, M.D., a pediatrician in Darien. "Especially for kids who are in school or day care, twice a day is a lot easier. And

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*"I don't get enough information from an ad to feel comfortable prescribing the product."*

**RICHARD K. BAER, M.D.**

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**CRAIG A. BACKS, M.D.**

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with kids, there's also the taste of the medicine to consider."

With new drugs appearing on the market every day, keeping up can become a problem. For information, physicians turn first to journals. "I rely on *The Medical Letter*, too," Dr. Backs said. "It's objective and unbiased. It's criticized for being too conservative, but I think it's very good at telling me if there really is an advantage in switching to something new. It also provides information about relative costs."

Professional meetings, colleagues, and consulting physicians also provide information on new products. "I'm in a group with four other doctors, and we share information," said Mark Rosenberg, M.D., a pediatrician in Barrington.

**ADVERTISEMENTS BY PHARMACEUTICAL** companies alert physicians to new products. "I'm interested in seeing what they have to say, but I have a higher index of suspicion when I read them," Dr. Baer said. "I look to see what they've left out. For instance, they tell you what side effects a new product *doesn't* have, but not which ones it does have. I don't get enough information from an ad to feel comfortable prescribing the product."

Pharmaceutical company representatives visit every physician. Dr. Daskal calls detail men his "No. 1 source" and feels that most reps do a good job of disseminating information.

"I see all the drug reps," said John E. Tillis, M.D., a Rockford Ob/Gyn. "I tell them they have 60 seconds to get everything off their minds. But they are helpful with new products, and they do send you literature."

Dr. Backs sees reps on a controlled basis. "I talk to one a day during lunch time," he said. "And I appreciate it when they bring lunch. I don't think these lunches affect my prescribing habits. The reps may get me to try something new, but I'll continue to use it only if it's good for my patient."

Despite all the sources of information, Chicago internist Vasanth M. Surath, M.D., sometimes feels overwhelmed. "The new drugs are valuable in management, but the knowledge base we have to keep updating has quadrupled in the last two to three years particularly in hypertension, heart disease, stroke prevention, and arthritis," he noted. "Keeping up with drugs should form a major part of a physician's continuing education effort; otherwise you will be out of date, increase your liability and become a poor physician."

Physicians must consider which drugs are reimbursable. Medicaid, public aid, some insurance companies and some HMOs require prior approval for certain drugs. "They give the approval readily, but you have to ask," Dr. Backs said. "I think their theory is, if they hassle you about it, you'll only do it when it's most effective

for the patient."

Mail-order pharmacies are another recent wrinkle on the prescribing scene. "Writing prescriptions to some of them is more inconvenient for me because I have to fill out the prescription for a certain amount of medicine and for a certain number of refills," said Stephen R. Goetter, M.D., an internist in Decatur. "It has to be exactly right or they send it back."

"But, if it's quality medicine and if the patients can save a few bucks, we owe it to them to take the extra time."

Saving money through mail-order pharmacies involves ordering in bulk. For psychiatrists, that can be a problem. "It's OK for lithium but not Valium or anti-depressants," Dr. Baer said.

Overall, a physicians' main goal in prescribing medicines is to help their patients. "You want to individualize the decision based on the patient's needs and your familiarity with the drug," Dr. Staunton said. ■

## MARKETING TRENDS

### The days of wine and roses give way to patient promotion, cooperation and cost-effective appeals

*To head off government scrutiny and deflect criticism of prices, pharmaceutical manufacturers adopt new marketing tactics, including advertisements to patients. By Kathy Meyer*

**G**one are the days of glitzy dinners and weekend getaways sponsored by some pharmaceutical companies to promote their products. To head off increased government scrutiny and claims of "unjustifiable" prices, drug firms nationwide are abandoning these promotional practices in favor of more traditional approaches to marketing their products to patients and physicians alike.

Once taboo to pharmaceutical companies, consumer advertising has now found its place among the arsenal of pharmaceutical marketing strategies. Ads touting nicotine patches for people trying to stop smoking, remedies for baldness and estrogen therapy for women are commonplace in the media. Less common is an approach such as Marion Merrell Dow's consumer ad campaign promoting its new once-a-day hypertension drug, a program the company says is intended to facilitate compliance. The approach is educational, informing patients that a new form of treatment is available and encouraging them to ask their physician about the product.

In addition, pharmaceutical companies are becoming more aggressive in capturing sales once considered lost due to patients' failure to take their medication as prescribed. Because noncompliance is particularly high among hypertension patients, both ICI Pharma and G.D. Searle & Co. have launched programs to help remind consumers to take their medication and refill their prescriptions. Participants in ICI's "Wellspring Service" receive timely reminders in the mail, along with tips and incentives for healthy living. Searle goes one step further in its "Patients in Compliance" program, actually telephoning participants over a four-week period to reinforce physicians' directions.

**TO COUNTER CLAIMS** of price gouging, most pharmaceutical giants now provide prescription drugs free or at low cost to indigent patients. The Bristol-Myers Squibb Co. recently added 17 heart, blood pressure and cholesterol-lowering drugs to its charity list of several cancer drugs and its new AIDS drug. These are available to patients whom physicians certify as having no insurance or other means of paying for their medication. Searle's "Patients in Need" program has donated more than 800,000 months' worth of various

(Continued on page 18)



# If you could say anything to a detail man, what would it be?



**M. Anita Johnson, M.D.**  
Internist, Chicago

Be brief and to the point. I want to know the bottom line. How is the drug going to help my patients?

I also want them to know that I appreciate their company for the research they perform. That research supports the progress of medicine.



**Tim C. Kisabeth, M.D.**  
Ob/Gyn, Alton

Present things like *The Medical Letter* to me. Facts and details about pharmacokinetics, appropriate use of drugs and their cost-effectiveness. Don't tell me all the miracle things [a drug] can do. Tell me clinically how it's best applied.



**Joseph L. Murphy, M.D.**  
Internist, Chicago

One thing that really bugs me is that they always feel they have to knock the competing products. They can't just present their own [product] – its benefits and all – they have to be negative about everybody else's product.



**James B. Borgerson, M.D.**  
General practitioner, Mt. Pulaski

Specifically, I ask for reprints of articles and more information than I can get in the *PDR*. They [drug reps] train in a very narrow line of products. They know a whole lot about maybe three drugs, and they plug those. That gets a little tedious sometimes.

Interviews by Anna Brown; Photos by William Daniels/The Photo Partners

## Marketing trends

(Continued from page 17)

cardiovascular drugs to about 125,000 patients since its inception in 1987, the company said.

The evolution of managed care probably has had the most dramatic effect on pharmaceutical marketing in the past decade. Because managed care entities determine which products are reimbursable, drug companies must convince the organization that their product provides the best treatment for the dollar. This emphasis on drugs' cost-effectiveness is expected to increase in coming

years as pharmaceutical companies not only battle for wide acceptance but also work to guarantee premium prices.

These trends do not indicate a move away from physician contact, industry sources say. Rather, physician contact is expected to become increasingly important. The science behind pharmaceuticals will become more complex, drug companies predict. As a result, the drug rep's role may become more one of educator than of marketer, requiring more conversance in the science that makes pharmaceutical products successful in treating specific medical conditions.

Several pharmaceutical firms are

already trying to boost their sales forces by teaming up to co-market certain products. Co-marketing agreements help companies expand into markets where they may have no established presence. For the Burroughs Wellcome Co. to inform pediatricians about its oral antiviral therapy for chicken pox, it chose to join forces with Wyeth-Ayerst Laboratories, a company with extensive contacts with pediatricians nationwide.

Whatever route pharmaceutical companies take in marketing their products, physicians and patients alike stand to benefit from the emerging emphasis on education. ■



The services, staff and leadership of the Illinois State Medical Society and the Illinois State Medical Inter-Insurance Exchange are as near as your phone. Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654. Both the Society and the Exchange phone lines are open from 8:30 a.m. to 4:45 p.m. Monday through Friday; during nonbusiness hours the night line can record brief messages.

In addition, ISMS President Arvind K. Goyal, M.D., is available for membership calls the first Wednesday of every month. Use the toll-free or Chicago number above and ask for extension 1333. ■



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# Pharmaceutical R & D expenditures continue to rise

**TRENDS:** Companies' efforts to stay competitive lead to new drug breakthroughs and big spending.

By Anna Brown

[ WASHINGTON, D.C. ] Research and development in the pharmaceutical industry is a subject that most companies veil in secrecy. Competitive secrets range from amounts spent on R & D to trends that affect that expenditure, such as liability and competition itself. The Pharmaceutical Manufacturers Association, which collects data on R & D from its member companies, keeps statistics that indicate such expenditures will continue to rise.

Since the first large-scale production of drugs was spurred by World War II, the pharmaceutical industry's emphasis on research and development has continued to intensify. According to the PMA, private pharmaceutical companies account for more than half the biomedical research and development in the United States, with R & D expenditures doubling every five years since 1970. The average percentage of sales reinvested in R & D is 16 percent, according to the PMA, and the private pharmaceutical industry accounts for 95 percent of patents for the 100 top-selling drugs.

Unlike other industries, the pharmaceutical industry sees only a small portion of R & D spending result in salable products. Companies have estimated that out of 2,000 tested chemicals, 200 may show some potential in early tests and 20 may eventually be tested on human subjects. Out of the original 2,000, only one may be approved by the FDA and make it to market. Past PMA estimates have placed the success rate for new drug products at one in 10,000.

Despite such figures, the PMA believes that new advances in biotechnology and molecular biology have led to the "second pharmaceutical revolution of our time." Recent medical therapies have saved 600,000 lives from heart disease, prevented 500,000 stroke deaths and reduced the need for corrective ulcer surgery, the association says. It predicts major research advances in the next 25 years in the treatment of cancer, Alzheimer's disease, arthritis and osteoporosis, and AIDS.

**A MAJOR FACTOR** in R & D costs, companies say, is the time it takes to get a product from conception to the pharmacist's shelf. Although many manufacturers agree that much of that time is spent in the FDA approval process, some companies are taking steps to decrease the time a drug spends in development.

North Chicago-based Abbott Laboratories, a major manufacturer of pharmaceuticals and health care products that invested \$666.3 million in research and development in 1991, has created an express route for especially viable new products. In 1985, Abbott created a system of four "venture groups" that streamline the development process. The groups focus on products that fall into categories of anti-infectives, cardiovascular, immunoscience and neuroscience, said Clair M. Callan, M.D. Dr. Callan, chairman of the Illinois State Medical Society Medical Legal Council, will head a yet-to-be-announced fifth venture group.

"Through Abbott's system of strategic planning, some high-potential products

are targeted for faster development in the venture system," Dr. Callan told *Illinois Medicine*. A venture group comprises a clinical staff and an operations manager who work within a multidisciplinary matrix, she said. The matrix system allows researchers from many different fields of expertise to help develop a particular product. As that product reaches different stages of development,

the composition of the team will evolve with it. The process allows for greater resource flexibility since researchers need not work full time over long periods on a single product.

Through the venture system, Abbott hopes to reduce product development from a 10-year process to no more than four years.

Dr. Callan explained the importance

of marketing groups under the current 10-year process. "These groups play a key role in identifying what new products are needed and will still be needed 10 years later," she said.

The American Medical Association recognizes that the introduction of successful new products is key to the profitability of individual drug firms. Although many pharmaceutical companies do not deny that R & D expenditures lead to higher consumer prices, the PMA predicts that such spending is not likely to decrease and is necessary for continuing drug breakthroughs. ■

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Medical Management of America, headed by James H. Desnick, M.D., and comprising mostly hospital staff physicians, will officially take control of Hyde Park Hospital Sept. 18.

## Physicians buy bankrupt South Side hospital

**TURF WAR:** A bidding battle between a physician group and the University of Chicago School of Medicine centered on which would maintain more jobs at Hyde Park Hospital. By Anna Brown

[ CHICAGO ] The fate of Hyde Park Hospital, which filed for Chapter 11 bankruptcy protection last November, is now in the hands of James H. Desnick, M.D., an ophthalmologist known throughout Chicagoland for television promotion of his Desnick Eye Centers. On Aug. 17, Dr. Desnick's company, Medical Management of America,

offered a bid of \$2.4 million to purchase the hospital. That bid was accepted by a bankruptcy judge mediating for the hospital. The only other bidder, nationwide management company Ramsey Health Care, bid \$3 million to turn the facility into a psychiatric hospital for the University of Chicago School of Medicine department of psychiatry. Both parties

speculated that the lower bid was accepted because Medical Management said it planned to retain all employees at the hospital.

For the past three years, the University of Chicago has sought a facility in which to install the entire psychiatry department, said William P. Travis, Ph.D., Ramsey vice president for development. Ramsey Health Care is a 15-year-old publicly traded company that owns 18 psychiatric hospitals throughout the country. "We're disappointed [our bid] didn't work out," he said. "The judge bought the argument that the other group [would] continue to employ everyone. We had a long-term focus for the use of the facility. The judge went for the 'here and now.'"

General partner Medical Management of America and limited partner Hyde Park Physicians Partnership wanted to maintain the hospital's current medical-surgical status, Dr. Desnick said.

"This was a community effort," Dr. Desnick said, adding that the physician group was backed by Hyde Park community organizations. He said that the community supported the effort to keep the 450 jobs that were at stake.

According to Dr. Desnick, the judge said the employment issue was not a factor in the decision.

**DR. TRAVIS TOLD** *Illinois Medicine* that "complicated transitional plans" would have taken a year to turn Hyde Park Hospital into a full-service psychiatric hospital with continuing research and teaching programs. He said the transition called for retaining 100 employees, a number that would eventually grow to 700. Hyde Park Hospital has a current census of 75 to 80 patients and 450 employees, he said.

"The judge wasn't looking to the future," Dr. Travis continued, explaining that current patients would have been transferred to area hospitals and that half the staff was made up of nurses who "could get a job anywhere."

Hyde Park Hospital currently runs a substance abuse treatment unit, which, Dr. Travis said, would have stayed had Ramsey won the bid.

**THE JUDGE WAS PERSUADED** to accept Medical Management's bid because of "significant closing costs," which could have totaled \$3 million, the amount of the Ramsey bid, said Hyde Park Hospital President and CEO Vasanth Pai. "A strong argument was made by other hospitals that it doesn't matter if Hyde Park goes under. But we have existed since 1914. Patients and their children have been born and grown up here. We have a strong affiliation with the local community."

Pai joined the hospital in February, when he formed the physician partnership and contacted Dr. Desnick. He said the hospital had reached the level of bankruptcy because of the "changing health care environment, poor management and lack of vision."

According to Pai, Hyde Park is the first hospital in Chicago to survive bankruptcy.

Medical Management plans to begin upgrading the hospital as soon as the takeover is complete. Improvements will be made to the physical plant, he said, and new physicians will be brought in. He also plans to institute an eye center. "Changes will take place in weeks, not years," he promised.

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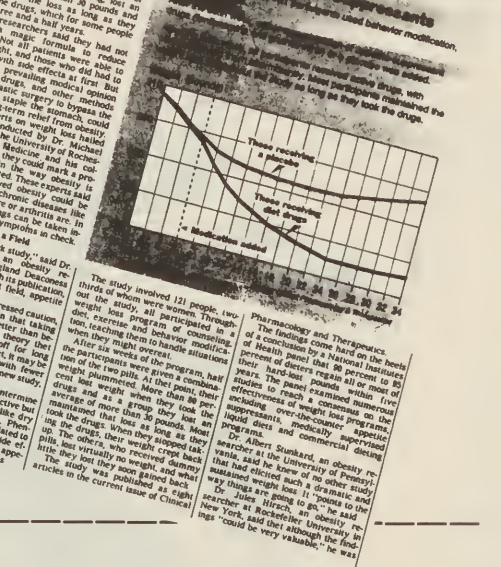
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## National Report

The New York Times  
SUNDAY, JULY 5, 1992

### Drugs Found to Keep Lost Flab Off





## OBITUARIES

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

**\*Bernat**

Thomas S. Bernat, M.D., of Rapid River, Mich. (formerly of Chicago), died May 20, 1992, at the age of 56. Dr. Bernat was a 1959 graduate of Loyola University Stritch School of Medicine, Maywood.

**\*\*Breisch**

Warren F. Breisch, M.D., of Mazon, died April 20, 1992, at the age of 90. Dr. Breisch was a 1931 graduate of Chicago Medical School.

**Coffey**

Brian T. Coffey, M.D., of Barrington, died May 15, 1992, at the age of 58. Dr. Coffey was a 1960 graduate of the Medical College of Wisconsin, Milwaukee.

**Goldsmith**

Jewett Goldsmith, M.D., of Northbrook, died May 14, 1992, at the age of 73. Dr. Goldsmith was a 1942 graduate of the University of Maryland School of Medicine, Baltimore.

**Keyes**

Arthur Lee Keyes, M.D., of Hinckley, died April 16, 1992, at the age of 98. Dr. Keyes was a 1925 graduate of Chicago Medical School.

**Mamby**

Audley Rich Mamby, M.D., of Chicago, died July 26, 1992, at the age of 75. Dr. Mamby was a 1945 graduate of the University of Michigan Medical School, Ann Arbor.

**\*\*Schwartz**

Isadore Schwartz, M.D., of Rockford, died July 16, 1992, at the age of 81. Dr. Schwartz was a 1938 graduate of Chicago Medical School.

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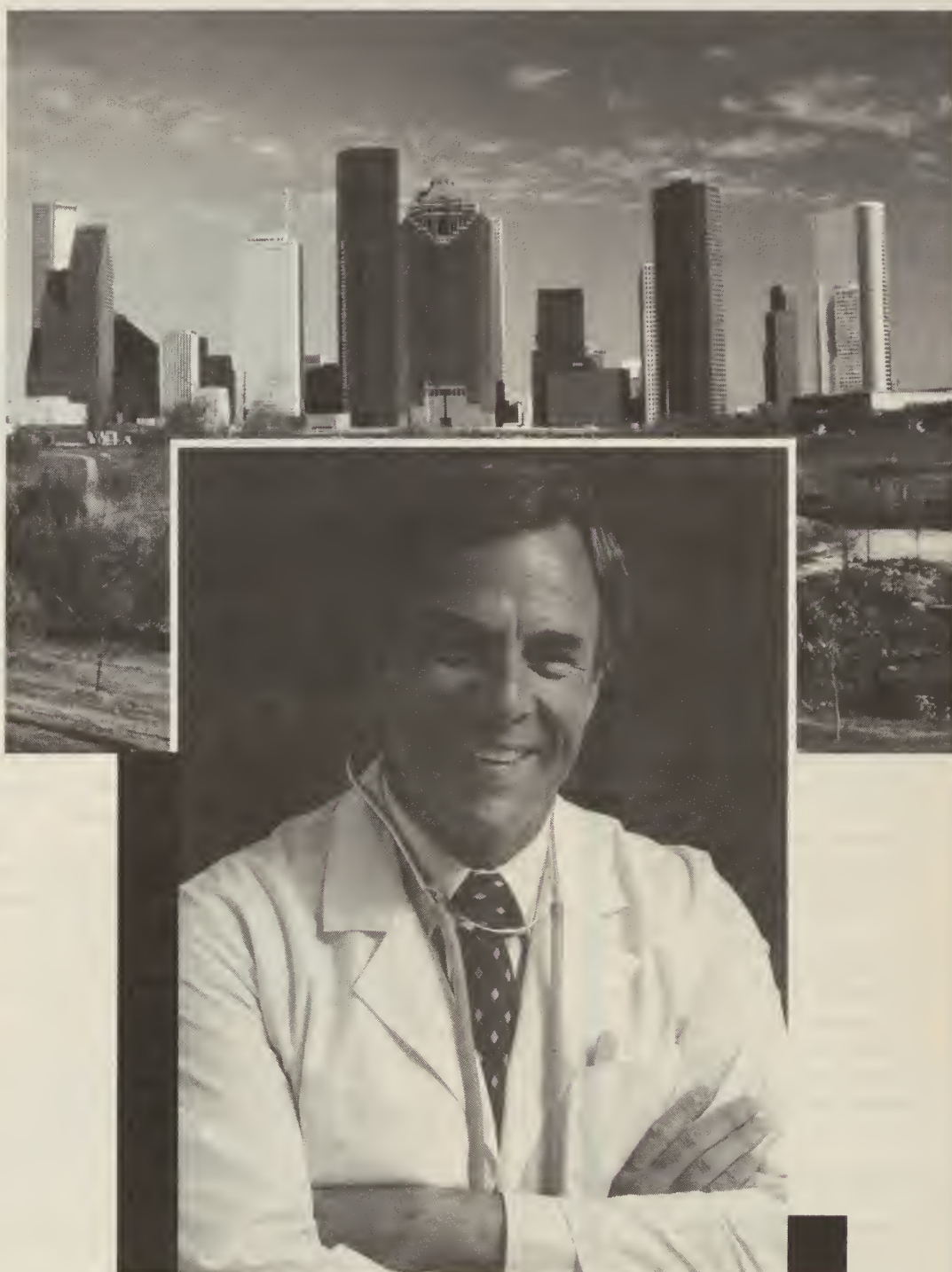
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## Pharmaceutical review for public aid coverage

(Continued from page 1)

[list]," said committee member Marshall L. Blankenship, M.D. "The opinion of the committee member with the most experience with a particular kind of drug carries the most weight [in a discussion], but we all read all of the literature. We consider all aspects of the drug and [recommend] those that will give the most benefit. Cost is the least important factor, but it still must be considered."

Although not all drugs are approved by the committee, physicians can obtain prior approval for medications not on the drug list needed by their indigent patients. Both Dr. Perez and Dr. Blankenship strongly recommend that physicians learn how to obtain prior approval from IDPA.

Physicians may obtain prior approval for any drug not included on the IDPA drug list if the requested drug is to be used in lieu of hospitalization or to prevent a higher level of care, and if alternate therapies on the list would not be effective in treating the condition. The requested drug must be prescribed in accordance with standards and indications approved by the FDA.

*"I've heard physicians moaning that they need specific drugs when they never knew prior approval existed. It's easy to get, and physician requests are rarely turned down."*

JOSEPH B. PEREZ, M.D.

Requests for prior approval may be initiated by prescribing physicians or their office staffs. The department also accepts requests from pharmacists, social workers or other individuals under the direction of a prescribing physician. Requests must include the patient's name and address; the case identification number; the recipient identification number; the diagnosis; the requested drug, including strength, dosage and quantity; and identification of the prescribing physician and dispensing pharmacist by name, address and provider number.

Physicians may write to the Illinois Department of Public Aid, Attention Drug Unit - Prior Approval, P.O. Box 19117, Springfield, IL 62794-9117 to request prior approval. Telephone requests may be made by calling (800) 252-8942. A written request must follow a phone request.

The department's turnaround period for prior approvals is 24 hours.

"I've heard physicians moaning that they need specific drugs when they never knew prior approval existed," Dr. Perez said. "Prior approval [prescriptions are] good for one year. It's easy to get, and physician requests are rarely turned down."

"Teaching physicians how to obtain prior approval is a continuous project

for us," he told *Illinois Medicine*. They may think obtaining prior approval would be too much trouble, according to Perez. "It's really as easy as a phone call," he said.

"There is no drug that [eligible] public aid patients can't get," Dr. Blankenship said.

WHEN THEY FIRST BECOME available, all new drugs are automatically included in the

department's list for six months because of federal mandates. After that, with the exception of drugs Illinois law requires to be covered, such as antibiotics and certain chemotherapy drugs, the products are reviewed by the committee at the manufacturers' request. The six-month period of coverage gives committee members a chance to become familiar with the medication. "We read about experiences other physicians have had with the product, which helps us form an opinion," Dr. Perez said.

If the committee rejects the product, the manufacturer is given an opportunity

to appeal by presenting more information. "It's not unusual to have three appeals at a meeting," Dr. Perez noted. "We do reverse our stance, usually when we receive new information [that addresses our concerns]."

"There are two reasons why some drugs are not approved [by public aid]: if there is a similar drug on the [list] or if the medication is too expensive for the department," he said. The committee's job is to make sure that public aid patients have access to quality products, according to Perez. ■



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## Elective abortions at Cook County Hospital

(Continued from page 1)

per week, with 10 procedures per day and scheduling of appointments would begin Sept. 14.

Joseph M. Scheidler, executive director of the Pro-Life Action League, said his organization has revived a suit it filed in early August to block resumption of the procedure. There is some doubt, however, whether the group has legal standing to sue. In any case, Scheidler said if abortions resume, the organization not only will demonstrate at the hospital but will picket homes of physicians, nurses and other staff members who participate.

## Geriatric & Chronic Care Medicine

A unique opportunity to teach and practice geriatric medicine and chronic diseases is offered by Oak Forest Hospital, located in Chicago's south suburb, Oak Forest. Oak Forest Hospital is a 1,100-bed multi-level chronic disease hospital operated by the County of Cook which also serves as an educational resource in geriatrics and long-term care. The Department of Geriatric Medicine and Chronic Diseases at Oak Forest is affiliated with the University of Chicago through a joint fellowship program in Ethics. Internal medicine residents rotate from Cook County Hospital, for training in geriatric medicine.

Attending physicians are responsible for the primary care of long-term care patients and instruction of resident physicians. The candidate should be Board Certified or eligible in Internal Medicine and have experience or interest in geriatric medicine.

The compensation package for this position offers, in addition to the salary, very liberal benefits, including twelve paid holidays, ten days paid educational leave per year, three weeks paid vacation, and regular working hours, employer-paid health insurance and dental benefits, a generous pension plan, and a tax-deferred compensation plan. Malpractice insurance is covered by the County. Oak Forest Hospital is an equal opportunity employer offering the opportunity for clinical practice, research and teaching in a pleasant and comfortable environment. For more information, please contact Cynthia T. Henderson, M.D., M.P.H., at (708) 633-4125/6. All inquiries will be treated with the utmost confidentiality.

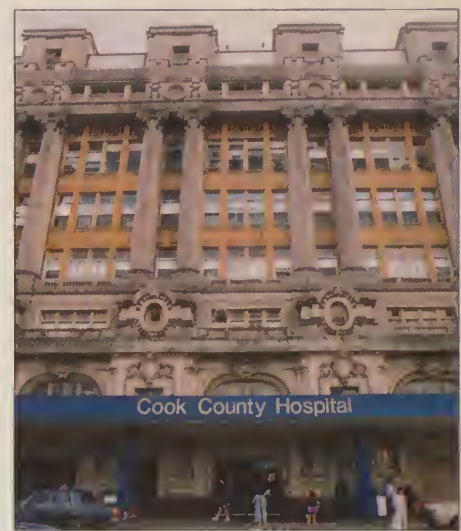
The controversy began June 18 when Phelan issued his executive order. Elective abortions at Cook County Hospital stopped on Oct. 9, 1980, when former Cook County Board President George Dunne issued a directive that they cease. On Nov. 24, 1980, the board, sitting as the Hospitals Committee, acceded to Dunne's request that it "concur" with his Oct. 9 directive.

In a four-day hearing, the plaintiffs contended that the board's concurrence with Dunne constituted board policy and could be changed only by subsequent board action. The defense countered that because the board did not follow its rules of procedure when it took

its November 1980 action, it had not passed a legal ordinance or resolution stopping elective abortions. Consequently, no board policy existed, the defense claimed, and Phelan acted properly when he reversed Dunne's action.

The judge agreed, but in so doing he also said the board has the right to establish a policy that would supersede the president's executive authority if it so desired. In fact, O'Brien had harsh words for the board's failure to resolve the current dispute itself.

"This is a perfect example of legislative timidity that seeks the comfort of submitting a controversial issue to the judiciary, inviting it to be a surrogate decision maker on issues legislators were elected to decide," O'Brien said. ■



Abortions are scheduled to resume Sept. 17 at Cook County Hospital.

## Several races of interest to physicians

(Continued from page 1)

ton, Williamson has an uphill fight against the popular Braun.

A LOSS OF POPULATION reduced the number of Illinois' congressional districts from 22 to 20, which could have prolonged the congressional redistricting process. But unlike the controversy that accompanied the General Assembly's remapping process, consensus on new congressional boundaries was reached early. The new map provided eight contests of particular interest to physicians.

In most of the congressional races profiled in this issue, the candidates articulate varied views on health care reform, although there are instances of agreement on caps.

In the 16th Congressional District, for example, Rep. John W. Cox Jr. used an Aug. 24 meeting of the Winnebago County Medical Society to announce he had changed his mind on tort reform. Running for Congress two years ago, Cox told *Illinois Medicine* that he opposed caps, saying, "I'm a practicing attorney; I really believe in the jury system."

In his speech to the Winnebago Coun-

ty physicians last month, Cox credited his turnaround to the work of a health care advisory committee he formed in the district. He said the group — composed of representatives of all fields concerned with health care, including physicians — educated him on the issues. "These meetings have provided me with valuable insight into such issues as medical malpractice tort reform, cost containment and antitrust reform," he said.

Citing the year-long education process, several physicians said Cox's conversion appeared genuine. His opponent, Republican Donald Manzullo, who shared the platform with Cox, supports a "flexible" cap that would vary according to the seriousness of the plaintiff's injury.

MOST OF THE DEMOCRATIC candidates expressed their preference for a health care reform plan that vests control in the federal government, some saying they support the single-payer universal plan introduced by Illinois Rep. Marty Russo. Russo, however, lost his primary bid against fellow incumbent William Lipinski and will not return to Washington.

The fate of his proposal is uncertain.

Three Republican candidates, including two incumbents, expressed strong support for a congressional Republican leadership proposal. The "Action Now Health Care Reform Act of 1992" has been refined from a proposal by the Heritage Foundation, a Washington, D.C.-based conservative think tank.

The plan's salient feature is the "MediSave" savings account. Under this approach, a group plan costing an employer \$4,500 with a \$200 deductible would be changed to a \$3,000 deductible, with the employer spending about \$1,500 on major medical coverage. The other \$3,000 would be placed in an employee "MediSave" savings account that could be tapped to satisfy the deductible. Anything left in the account at the end of a given year would go to the employee to be used for health-related matters or retirement. This would realize a \$33 billion savings in administrative costs and \$147 billion in more prudent utilization of health care services by consumers, proponents said. The plan includes several other reforms, including revision of the tax code to permit self-employed individuals to deduct 100 percent of their health insurance premiums, as corporations do now. ■

## The PBT Challenge

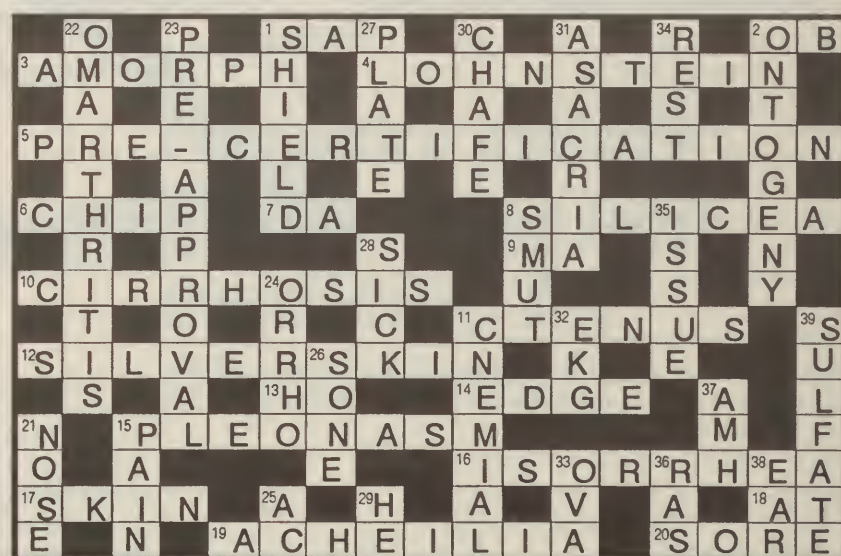
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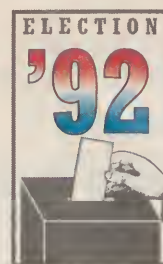


Illinois' vanguard  
women physicians

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# Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • SEPTEMBER 25 1992



A look at  
Illinois  
Senate races

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## HCFA grants 90-day CLIA grace period, drops unannounced inspections

**CLIA:** Physicians who have office labs and have not yet registered with the U.S. Health Care Financing Administration now have until the new Dec. 1 deadline to act. By Kevin O'Brien

[ CHICAGO ] Last month's dark cloud directly overhead has dissipated — a little. Physicians who do laboratory testing in their offices were supposed to have registered with the U.S. Health Care Financing Administration by Sept. 1. They now have until Dec. 1 to comply with the Clinical Laboratory Improvement Amendments of 1988 registration requirement.

"But they must be in the system by Dec. 1, not just get their application in by that date," said Elizabeth Clay Day, who handles CLIA matters for HCFA's regional office in Chicago.

Likewise, physicians who completed the mandatory HCFA Form 109 lab survey should by this time have received a certificate application and billing coupon for the registration fee.

"But many physicians have not yet received the application and billing coupons, although HCFA says they're mailing them out every day," said

Richard J. Sassetti, M.D., chairman of the Illinois State Medical Society Committee on Blood Banking and Laboratory Services. "So physicians who have registered can continue to do business while keeping an eye on their mailboxes." As soon as physicians receive their billing coupons, they should remit the registration fees.

**"HOWEVER, WE CANNOT STRESS** strongly enough that physicians who have not yet filed their HCFA Form 109 should delay no longer," Sassetti continued. "Failure to file could not only result in cessation of reimbursement for laboratory services, but also potentially steep financial penalties." Even physicians who perform simple laboratory tests in the office without charging the patient must register and obtain a certificate from HCFA.

The reprieve was granted when HCFA was unable to process the volume of HCFA Form (Continued on page 25)

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History repeats  
itself with the ISMS  
president's tour

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Hawaii and  
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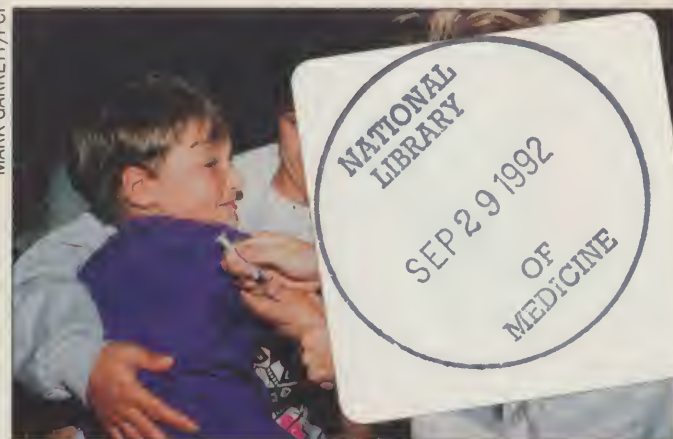
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MARK GARRETT/PCI



**SEVEN-YEAR-OLD CHRIS NIELSON** (left), of Carol Stream School, receives a vaccination from Carol Klimt, R.N., B.S.N. (right), of the DuPage County Health Department. Nielson's mother, Gina (center), brought Chris to Glenbard North High School in Carol Stream to get his shots before he entered the second grade.

## Exchange board adopts service initiative plan

After nearly two years of research and planning, the Illinois State Medical Insurance Exchange Board

of Governors on Sept. 11 unanimously and enthusiastically adopted a comprehensive service plan with specific activities and programs that will strengthen physician malpractice protection, minimize physician frustration with the legal process, reach out to policyholders in their local communities to serve them more personally, and respond speedily and thoroughly to any request.

"Board members recognize that policyholders want more than just financial stability," said Harold L. Jensen, M.D., Exchange Board chairman. "We want

to make a good company even better and assure that our programs and activities provide exceptional service

to Exchange physicians. Board members are committed to playing a major role in this ongoing initiative."

"The board's plan establishes a permanent structure for the Exchange to deliver top quality service," said Dr.

Jensen. "Because we are a physician-owned company, policyholders expect more from us. The level of expectation is beyond simple competence; we have to be friends and champions to our policyholders." Watch for comprehensive coverage on the service initiative plan in the next issue of *Illinois Medicine*.



Harold L. Jensen, M.D.

### THE ANNUAL PRESIDENT'S TOUR

## ARE YOU GETTING THE ISMS MESSAGE?

The No. 1 responsibility of the president of the Illinois State Medical Society is to carry the ISMS message to members and to bring their input back to the Board of Trustees.

Arvind K. Goyal, M.D., and presidents who have preceded him take this responsibility seriously. They relinquish personal and practice time to take ISMS priorities to members of county medical societies, hospital medical staffs and specialty societies.

September is usually the "launch" month for the ISMS president's tour, when the president hits the road. Dr. Goyal has 23 county medical society visits scheduled between September 1992 and April 1993, when his term ends, with six counties already visited. More can, and probably will, be scheduled.

The president brings member concerns back to ISMS. Those concerns cover a broad (Continued on page 25)

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## CMS receives 230,000 requests for interest payments on unpaid claims

[ SPRINGFIELD ] The Illinois Department of Central Management Services reports that 230,000 provider requests for interest penalty payments on unpaid claims have been received in the past year.

"When we started paying the interest last year, we had to set up a separate process on a PC," said Lynn Calame, manager of the Bureau of Benefits for CMS. "When the volumes of payment requests came in, we got nailed. We've got the system down now, and we're paying interest on a monthly basis."

The Prompt Payment Act requires the state to process claims on its Quality Care Health plan and dental plan within 30 days of receipt, and to pay claims within 60 days. If the time limit is not met on "clean" claims – those that do not require additional information from the provider or that contain no errors – providers may request a 2-percent interest penalty on the covered amount. Interest begins to accrue on unpaid claims after 60 days.

"When providers receive the payment depends on when they submit the requests," Calame said. Payment usually takes about a month, she said, because batching requests and paying them at one time is most efficient.

Calame said physicians do not need forms to request the interest penalty, but must write the department and enclose the Explanation of Benefits attached to the top of checks sent by Equicor or Dental Care Plus. "We must have the EOB to calculate the interest. It contains information such as the date of processing and the date of release," she said.

"Doctors should mail their requests as soon as possible after they receive the EOB," Calame added. "The sooner we receive requests, the sooner we can begin processing."

To request the 2-percent interest penalty, providers who have been assigned claim benefits may write to CMS Group Insurance Division, Prompt Payment Unit, Stratton Building, Room 600, Springfield, IL 62706. For more information, contact the CMS Prompt Payment Unit at (217) 782-2548. ■

## Parkside PPO announces name change, move toward managed care

[ DES PLAINES ] One of the largest preferred provider organizations in metropolitan Chicago, Parkside Health Management, is now Health Direct Inc. The managed care organization July 20 announced its name change, a new president and its move to Des Plaines from Park Ridge.

The name change "symbolizes an important trend in managed care – direct contracting or direct delivery of health care services by providers to the business community," the company said in a press release announcing the changes.

Charles Stark, the new president and chief executive officer of Health Direct, was formerly president and chief executive officer of MetLife Health Care Net-

## Blues' health plan calls for tougher insurance industry standards

**INSURANCE:** Blue Cross and Blue Shield Association proposes comprehensive health insurance reform to expand access to care. By Kathy Meyer

[ WASHINGTON, D.C. ] The nation's largest health insurer is calling for strict industry standards and federal oversight as a fundamental element of a new "pay or play" health plan it proposes.

Blue Cross and Blue Shield Association, the coordinating body of the 73 Blue Cross and Blue Shield plans nationwide, is proposing that the federal government regulate and supervise the health insurance market to "clean up" insurers' business practices. A brochure outlining the association's "Community Partnerships for a Healthy America" charges many of the country's 1,500 health insurers profit by insuring only healthy groups and individuals, avoiding those who need health care services the most. Under the proposed plan, insurers would have to meet "tough" federal guidelines for responsible market behavior in order to be licensed as Accountable Health Plans.

All Accountable Health Plans would be required to offer, at minimum, a basic set of benefits, including preventive care and portability, to prevent lapses in coverage when individuals change jobs. Because everyone would be covered for at least the basic benefits, there would be no need for limits or exclusions for pre-existing conditions in group policies.

Accountable Health Plans also would be required to make a strong commitment to reducing administrative costs. This would include adopting uniform electronic billing and data systems and establishing "Community Care Partnerships" with physicians, hospitals and other health care providers willing to provide high-quality, cost-effective services.

In addition, insurers would be required to accept individuals and small groups regardless of past or present health problems, and to set rates equitably. Often, individuals and small

businesses with employees who have any history of serious illness, like cancer, cannot obtain health insurance coverage or must pay exceptionally high premiums.

To ensure universal access to care, the Blues' plan would require large employers to provide defined health benefits for employees and dependents. Small employers would be required to contribute 80 percent of coverage or pay an assessment equal to 40 percent of premium costs – about 3 percent of payroll – to fund coverage through a separate government-run health insurance program.

Employees would have to accept company-sponsored coverage. Those not covered by their employer would receive a premium subsidy of 40 percent from the government.

Finally, the plan urges "adequate funding" of Medicare and Medicaid to expand coverage among the elderly and the poor. ■

work's St. Louis HMO. The PPO, which touts itself as a "pioneer" in managed care organizations, is a joint venture between Evangelical Health Systems in Oak Brook and Lutheran General Health System in Park Ridge. The parent organizations operate six hospitals with 2,600 beds and have combined annual consolidated revenues exceeding \$1.3 billion.

Health Direct plans to become a bigger player in Chicago's managed care market, according to Stark. "We'll offer a wider array of cost-reducing health care services to the business community. We'll expand our PPO products, utilization review services and behavioral health services to meet specific employer needs. Health Direct also plans to enter the insured arena with a variety of tailored products, including an HMO, by early 1993," he said.

Moving its corporate headquarters to Des Plaines provided the firm with larger quarters and better access to the metropolitan area and to both parent companies, the company said. Health Direct was founded by Lutheran General as Parkside Health Management Corp. in 1980. In January, Evangelical Health Systems purchased 50-percent ownership. It currently provides PPO services to 115,000 people in northern Illinois and utilization management services for 1 million nationwide. ■

## Study: Elderly lack health care program knowledge

[ CHICAGO ] Findings from a Rush-Presbyterian-St. Luke's Medical Center study show that senior citizens are less

aware of social services, long-term care insurance and Medicare coverage than previously thought. Results from the study, funded by the National Institute on Aging, are still being tabulated.

"We are astounded by how little senior citizens seem to know about health care options," said researcher Gerald Glandon, Ph.D. Dr. Glandon and Michael Counte, Ph.D., surveyed 402 Oak Park residents 65 or over about their knowledge of health care programs. "These were not poorly educated individuals; they could all read and were not generally disadvantaged," he said.

Dr. Glandon suggested that physicians act as "gatekeepers" for the elderly by providing information about programs and "pointing them in the right direction."

"A typical internist probably has about 40 percent to 50 percent of patient visits from people 65 and above," he said. "With fewer and fewer physicians specializing in geriatric medicine, the study's message to physicians is that they need to be aware of seniors' needs. They can't assume the elderly can access available resources themselves."

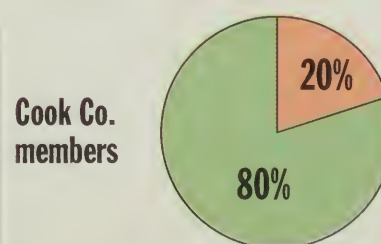
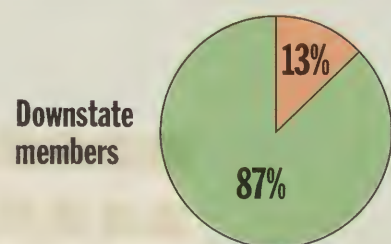
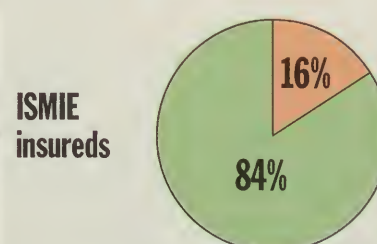
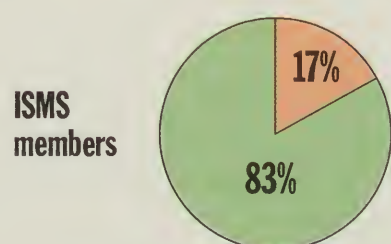
Each participant had coverage in addition to Medicare, either private insurance or an HMO. Participants were surveyed four times over a three-year period.

(Continued on next page)

## PHYSICIAN FACTS

### ISMS members by sex

Women Men



Source: The Illinois State Medical Society, as of September 1992.

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## ISMS board adopts new CME standards; Society to host 5th annual seminar

**CME:** New standards governing commercial support of continuing medical education were adopted by the ISMS Board of Trustees. The standards are more comprehensive than previously approved guidelines. By Kevin O'Brien

[ CHICAGO ] New standards for commercial support of continuing medical education, recently established by the Accreditation Council for Continuing Medical Education, were adopted Sept. 12 by the Illinois State Medical Society Board of Trustees.

Board adoption of the new standards was necessary because ACCME had said the standards would now apply to all accredited CME sponsors, including ISMS. In addition, because ISMS also accredits intrastate CME sponsors (i.e., sponsors *within* Illinois), the board determined the new standards also would apply to these sponsors.

The new standards are more comprehensive than the previous "Guidelines for Commercial Support of CME" adopted a year ago. "The ISMS Council on Education and Manpower compared the current guidelines with the new ACCME standards and noted substantial differences," said Donald F. Pochlyly, M.D., council chairman. "Thus, in order to demonstrate the Society's intent to comply, the council recommended the new standards be adopted in toto."

The new ACCME standards resulted from increased pressure by the U.S. Food and Drug Administration for more stringent guidelines governing pharmaceutical industry support of CME programs. ACCME has been negotiating with the FDA in an effort to forestall direct government interference in the CME arena. "These actions not only represent sound CME policy, but should help ACCME demonstrate organized medicine's commitment to maintaining the integrity of CME programming and accreditation," said Dr. Pochlyly.

One of the requirements of the new standards is that sponsors require, as a matter of policy, disclosure of any significant interest or other relationship a faculty member may have with a commercial sponsor. The ISMS Council on Education and Manpower, in conjunction with the ISMS Committee on CME Activities, will work to develop a policy consistent with the new standards.

Meanwhile, ISMS will sponsor its fifth annual intrastate planners workshop

Oct. 2 at the O'Hare Holiday Inn in Rosemont. "CME Benchmarks for the '90s" will include explaining the new standards, applying for and maintaining accreditation, training drug company representatives to comply with the new standards, and creating effective CME programs. About 100 program planners representing between 40 and 60 accredited CME programs are expected to

attend. In addition, the seminar's 28-member faculty will include Dr. Pochlyly; Dean R. Bordeaux, M.D., chairman, and members of the ISMS Committee on CME Accreditation; Peter H. Rheinstein, M.D., director of the FDA Office of Health Affairs; and Dennis K. Wentz, M.D., director of the American Medical Association's Division of CME.

The ISMS CME intrastate accredita-

tion program itself was subject to an ACCME on-site review Aug. 13. Two surveyors representing ACCME's Committee on Review and Recognition conducted the review, which included interviews with ISMS leadership and staff. ACCME's decision on continued recognition of the ISMS program is expected in late October. ACCME recognition can be granted for up to four years. ■



# REPORT

## FOR *Illinois Physicians*

### ILLINOIS PHYSICIAN ADVISORY COMMITTEE

For some time now, the Health Care Financing Administration (HCFA) has been concerned about physician complaints that Medicare's administrative requirements compete with the time available for direct patient care and increase the overhead cost of practice.

In response to these concerns, HCFA formed a national Advisory Committee on Medicare - Physician Relationships.

One of the recommendations of this committee was that each Medicare carrier establish a Physician Advisory Committee which would focus on improving these relationships.

We are now in the process of forming a Physician Advisory Committee in Illinois, and invitations have been sent to prospective members.

#### Purpose

- To provide a means for physicians to gain information and participate in the development of local medical review policy,
- mechanism to identify areas which need improvement in the administration of the Medicare program and achieve resolution of identified problems,
- and forum for exchange of information between the physician community and Medicare

#### Membership

Representatives of state and specialty physician societies; peer review, medical management and state hospital associations; and a beneficiary group. Each is invited to designate one of its members to attend committee meetings.

#### Functions

- Distribute draft medical policies to colleagues for review and input to insure that the policies reflect the standard of practice in Illinois,
- disseminate information about Medicare issues obtained at the meetings to respective state and specialty societies,
- and advise Medicare about issues, administrative problems, inconsistent or conflicting medical review policies and new technologies, so that these subjects can be addressed in a timely fashion

The initial meeting of the committee will be held in October and will have two main objectives: to present an overview of Medicare's administrative operations and to conduct a working session addressing specific medical policies and administrative concerns. Future meetings will then be held on a quarterly basis.

(9/25/92)

### Study

(Continued from previous page)

od. "The study was designed to look at a group of senior citizens to see how their health status changes over a period of time," Dr. Glandon said.

The survey looked at the participants' familiarity with 15 prominent community social services. Dr. Glandon said few seniors could describe even somewhat familiar services such as Meals on Wheels.

Other surprising findings were that a lack of copayment did not increase the number of doctor visits by the seniors and that elderly people tend to wait until they are ill before seeking health care, Dr. Glandon said.

"The problem lies in the system itself," Dr. Glandon said. "It's fragmented. We have a big health care system, but it's not well coordinated. We don't have someone in charge for the elderly." ■



# Edgar acts on pending bills of interest to Illinois physicians

**BILLS:** Fall is here and, with it, action by the governor on bills approved by the General Assembly. By Kevin O'Brien

[ SPRINGFIELD ] Another fall ritual is under way as Gov. Jim Edgar wields his pen on pending legislation. During early September, Edgar took action on several bills of interest to Illinois physicians.



mammography standards in its breast cancer program summary. Also supported by ISMS, S.B. 1760 was sponsored by Sen. Smith and Rep. Barbara Flynn Currie (D-Chicago).

## Alcoholism and drug dependency coverage

*Illinois Medicine* reported in its Sept. 11 issue that Edgar Sept. 1 approved S.B. 1533, which requires insurance coverage of cancer drugs for off-label use if prescribed by a physician. On the same day, the governor signed legislation stipulating that health insurance policies covering inpatient and outpatient alcoholism and drug dependency treatment cannot exclude coverage for any medically necessary services provided by "appropriately licensed providers." S.B. 1815 was sponsored by Rep. Terry R. Parke (R-Hoffman Estates) and Sen. Joyce Holmberg (D-Rockford). ISMS did not oppose the measure.

**Professional counselors** Despite ISMS opposition, the governor also signed S.B. 2056. The bill allows the independent practice of clinical counselors, provided they meet state licensing requirements. The bill, sponsored by Sen. Emil Jones Jr. (D-Chicago) and Rep. Terry A. Steczo (D-Country Club Hills), creates provisions similar to those in place under the state's Clinical Social Workers' Act. Edgar vetoed similar legislation last year.

**Prompt payment** Calling them "unworkable and unaffordable," Edgar vetoed three of four bills designed to get the state to pay its bills on time. The

governor also amendatorially vetoed S.B. 1588, saying the changes he recommends "will address the problem without exacerbating it."

In general, the bills directed the comptroller to publish rules to enforce the Prompt Payment Act immediately. Currently medical providers cannot collect under the Act unless they file separate claims for each patient and unless funds are available. S.B. 1588 mandated late fees once the interest exceeded a certain amount, either \$25 or \$50, depending on the invoice. In addition, interest on the late payments would have accrued at a monthly rate of 1.5 percent. Edgar recommends an automatic threshold of at least \$50 interest due, an interest rate of 1 percent per month, and a late-payment period that begins 60 days after the invoice is due. For interest amounts between \$25 and \$49, vendors would continue to request interest.

H.B. 3587 required the state to automatically pay penalties of \$50 on late payments of medical provider invoices. It also stipulated that if approved invoices were not paid within 30 days, an interest penalty of 1.5 percent per month

beyond the 30-day period would accrue. H.B. 2697 required claims to be paid within 60 days, instead of the current 90 days, and to automatically pay interest penalties of \$25 or more on invoices. S.B. 1589 restored the Prompt Payment Act to its pre-1992 form to specifically include medical provider claims to IDPA among the "goods and services" covered by the Act.

Edgar vetoed all of these, saying H.B. 3587 unfairly extended preferential treatment to medical providers and that administrative costs in complying with all three would soar, thereby exacerbating the state's already critical budget problem.

"The best way to assure the state is no longer delinquent in paying its bills is to put its fiscal house in order," Edgar said. "By demonstrating a new fiscal discipline, state government is making real progress toward that goal. However, our budget problems did not materialize overnight, and it will take time and determination to make the state treasury as healthy as we would like." ■

**Women's health** Edgar approved S.B. 1647, directing the Illinois Department of Public Health to designate a staff member to handle women's health issues the department is currently not addressing. The Illinois State Medical Society originally supported the measure, which was sponsored by Sen. Margaret Smith (D-Chicago) and Rep. Donne E. Trotter (D-Chicago). However, ISMS encouraged an amendatory veto because of its objection to some of the bill's language.

The particular area of concern is the duty of "recommending treatment methods and programs that are sensitive and relevant to the unique characteristics of women." A letter sent to Edgar by Jere E. Freidheim, M.D., chairman of the ISMS Board of Trustees, stated: "The recommendation of particular treatment methods should properly not be the function of an Illinois Department of Public Health staff person, but rather the responsibility of a physician licensed to practice medicine in all its branches who has examined the patient, noted the particulars of that individual's medical condition, and made a judgment based upon his or her training and experience."

**Mammography standards** The governor also penned approval of S.B. 1760, which requires IDPH to include American College of Radiology-recommended

## Mammography insurance coverage

According to state and federal law, insurance coverage of mammograms is mandated under certain conditions. The following guidelines were provided by the American Cancer Society.

### Under private insurance

As of Jan. 1, 1990, Illinois law requires policies, contracts or certificates issued by health insurers to include coverage for breast cancer screening by low-dose mammography, in accordance with American Cancer Society guidelines for screening. Mammography was previously covered only for diagnostic or treatment purposes.

Specifically, the law mandates coverage for

- 1) one baseline mammogram for women 35 to 39 years of age;
- 2) a mammogram every one or two years for women 40 to 49 years of age;
- 3) an annual mammogram for women 50 years of age or older.

The law requires coverage whether or not symptoms are present, and whether or not the insurer is headquartered or located in Illinois.

The law also applies to supplemental Medicare policies provided through Blue Cross and Blue Shield.

Illinois law does not apply to individuals covered under "self-funded" or "self-insured" policies, because these are regulated at the federal level under the Employee Retirement Income Security Act (ERISA). Check with your insurer to see if this exclusion applies.

For more information, contact the Illinois Department of Insurance in Springfield at (217) 782-7446 or in Chicago at (312) 814-2427.

### Under Medicaid

Illinois and California are the only states that mandate screening mammography coverage for women receiving Medicaid; the guidelines are the same as under private insurance. The Illinois Department of Public Aid administers the coverage under its rule-making process. For more information, contact IDPA at (800) 252-8635 or (312) 793-4706.

### Under Medicare

As of Jan. 1, 1991, Medicare will cover screening mammography for women aged 65 and older every two years.

For disabled women, Medicare will cover

- 1) one baseline mammogram for women between the ages of 35 and 40;
- 2) biennial mammograms for women between the ages of 40 and 49 who are not at high risk for breast cancer;
- 3) annual mammograms for women between the ages of 40 and 49 who are at high risk for breast cancer;
- 4) annual mammograms for women between the ages of 50 and 64.

For more information, contact Blue Cross and Blue Shield of Illinois at (312) 938-8000. ■

## ISMS initiates talks with CMS and Biodyne over state contract

[ CHICAGO ] The Illinois Department of Central Management Services has awarded a contract to American Biodyne Inc. to perform utilization review of Biodyne-provided and other mental health and substance abuse services to state employees. Concerns about the two-year contract have prompted Illinois State Medical Society inquiries, and the ISMS Board of Trustees Sept. 12 directed ISMS to communicate its concerns to CMS.

Biodyne is a national provider with an office in Oak Park. The contract under which Biodyne will administer the CMS Member Assistance Program took effect July 1.

"The perception in the Illinois mental health community is that Biodyne has a history of increasing barriers to providing services in order to control utilization and therefore costs," ISMS President-Elect and Urbana psychiatrist Arthur R. Traugott, M.D., told *Illinois Medicine*. "We also question the process whereby a firm that provides managed care services also provides the utilization management."

Lynn Calame, manager of the CMS Bureau of Benefits, discounted the con-

flict of interest concerns, because providers in the Biodyne network still have independent practices.

She said that CMS had been aware of Biodyne's reputation as a heavy denier of claims but that CMS staff checked the company's background extensively. Calame added, "We have some goals and targets in the contract to ensure that utilization does not drop below an acceptable level."

Calame did not dispute the charge that minimal consultation occurred with state mental health providers, but maintained that "CMS' job is to administer the benefits program, and we did the job we are charged to do."

The ISMS Council on Mental Health and Addiction in its Sept. 12 report to the board said Biodyne has provided its UR criteria to the Illinois Psychiatric Society and will do likewise to ISMS.

"Biodyne has expressed an interest in developing a cooperative working relationship with the appropriate professional societies and has indicated its intention to seek further psychiatric participation in its network," the council said. ■



# History repeats itself every year with the ISMS president's tour

*The official president's tour begins its 25th year, giving ISMS presidents a chance to meet the membership and have a little fun along the way. By Rachel Brown*

Talking about health care issues in a small, cramped men's restroom was probably not what P. John Seward, M.D., had in mind when he was inducted as the president and official spokesman of the Illinois State Medical Society in 1980. But the restroom is where Dr. Seward found himself when a routine radio interview was relocated due to constant interruptions.

Dr. Seward's interview, part of his official president's tour, is just one example of how he and other ISMS presidents reach out to various audiences. Historically, ISMS presidents travel through Illinois during their terms to educate the media and the public on issues important to the Society.

But not until 1967, with the presidency of Caesar Portes, M.D., did the Society first develop a structured president's tour to formally communicate with its grass roots members, county society officers and community leaders. Since then, the president's tours have evolved along with each president's particular goals and interests.

1988 President Edward J. Fesco, M.D., used his tour to speak out on AIDS. It was also during his term that the successful ISMS "AIDS and Adolescents" program began, sending hundreds of volunteer physicians into junior and senior high schools to educate teens about AIDS education and prevention.

Volunteering at public health clinics is one innovative way current president Arvind K. Goyal, M.D., wants to spread the ISMS message of preventive health care to nonmembers and the public.

"It is important to create opportunities where [ISMS] can be more active and visible in carrying out [its] public health agenda," said Dr. Goyal.

George T. Wilkins Jr., M.D., president in 1978, feels that although each president chooses a unique message for the year, the tour "really blossomed" and changed under Jerry M. Ingalls, M.D., who was president in 1976.

Dr. Ingalls credits this change to the Society's unique situation and the strong political awareness among members at that time. During those years, the malpractice insurance crisis initiated the founding of the Illinois State Medical Inter-Insurance Exchange. Dr. Ingalls made a concentrated effort to visit all county medical societies and educate the media as much as possible, according to Dr. Wilkins.

The strong involvement and cooperation of ISMS leadership and members helped contribute to the "cohesiveness"



of the Society as well, Dr. Ingalls recalled.

BY VISITING VARIOUS Illinois counties, taking important ISMS messages to the members, and bringing their concerns back to the Board of Trustees, the president is able to best serve the Society's growing membership.

In his travels throughout the state, Joseph Skom, M.D., a native Chicagoan, familiarized himself with the downstate membership.

"Serving as president gave me a good feeling about how grass roots membership [works] and [helped me] realize their concerns are similar to [those of] the urban membership," he said.

Often presidents such as Robert M. Reardon, M.D., have found that their comments made a lasting impact on others. One of Dr. Reardon's most memorable experiences occurred during a presentation to a Rotary Club in Rockford. After his speech an audience member told him, "I support national health care, but after hearing your comments, I am going to rethink my position."

Sometimes presentations can serve as humbling experiences for the president, as Dr. Skom discovered firsthand. During his 1977 term, he addressed the students at Western Illinois University in Macomb. A week after delivering what he felt was one of his better speeches, he received a copy of the university's student newspaper with the headline

"Skom bombs."

"I remind myself of that whenever I start to get cocky," Dr. Skom laughed.

AS WELL AS ENABLING the president to meet hundreds of ISMS members, the president's tour also gives physicians the opportunity to travel throughout Illinois and get a "flavor of the state," said Dr. Reardon, a native of Brooklyn, N.Y.

Past President Morgan M. Meyer, M.D., got a taste of southern hospitality during a trip to the Jackson County Medical Society in 1986.

According to Dr. Meyer, his car broke down at a truck stop outside Nashville less than an hour before his presentation in Carbondale. With nowhere to service the car or lease a new one, he thought the situation was hopeless. To Dr. Meyer's surprise, however, a waitress at the truck stop handed him her keys and offered her car.

"The fact that she would give us her car just shows the good-heartedness of the downstate and central Illinois people," he said.

Dr. Skom was able to see a little more of the Illinois countryside than he had hoped for after a presentation to the

DeKalb County Medical Society in 1977. Several hours after the meeting had ended, Dr. Skom and the ISMS staffer driving with him realized they were heading the wrong way — when they saw a sign for the Iowa border. It was 5 a.m. when they finally made it back to Chicago, Dr. Skom recalled.

Despite these unusual situations, traveling the state and interacting with the members give a unique and different per-

spective to the duties of an ISMS leader.

"I enjoyed meeting so many people and listening to what physicians in the daily grind of medical practice had to say about the issues that affect them," said 1987 ISMS President Jere E. Freidheim, M.D.

Dr. Seward agreed: "The members were exceedingly hospitable and uniquely cared about their patients. It made me pleased to represent [them]."

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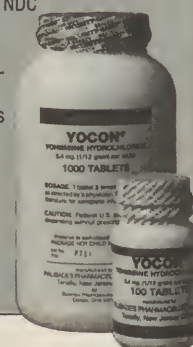
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## EDITORIAL

# No more lady doctors

The most disturbing factors about "Women in Medicine" month are not the facts and statistics, although some of them are pretty disturbing: Women physicians earn, on average, less than their male counterparts in any given area of medicine; women tend to select the (lower paying) primary care specialties; and women still encounter some bias and discrimination in medical school and medical practice.

No, the most disturbing thing is that we have to have "Women in Medicine" month at all.

These days, women are pretty much free to select the profession of their choice, and are restricted only by their ability to perform in the job or occupation they choose. Women are astronauts and accountants; women drive trucks and squad cars; women broadcasters anchor the news and women bank robbers make the news.

So we really shouldn't have to make such a big deal about women in medicine. We even have the answer to Freud's question, "What do women want?" as it pertains to lady doctors.

Women do not want to be special, in medicine, because of their gender. They just want to be accepted. They want to be judged on their ability to diagnose pancreatitis, not on the way they look in pantyhose. They want to be taken seriously as people and as physicians, and they want to be included in the professional network that helps qualified practitioners advance their careers.

In the Illinois State Medical Society, women are an integral part of the organization's leadership. Women physicians serve as members of the Board of Trustees, as members of various councils and committees; some councils and committees are chaired by female members of the Society. Women physicians serve as members of the ISMS House of Delegates and as delegates to the AMA House, as well. In addition, they are also active in other agencies of the AMA and in their specialty societies. As such they deserve recognition because of their commitment to medicine and to the public health – not because they had pink blankets on their nursery cribs, rather than blue.

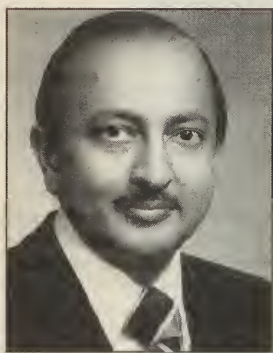
The most blatant anti-women discrimination in medicine has ceased in hospitals, in boardrooms and in medical schools. That doesn't mean there isn't room for improvement. It just means that maybe it's time to stop the practice of singling out women in medicine because of their gender. Let's honor and respect our female colleagues not because they're lady doctors – but because they're good doctors; committed doctors; honest, caring and professional physicians.

Most of the staff and members of the Society and the profession would swallow their tongues before they'd refer to a female practitioner of the medical arts as "babe," "chick" or "gal." Let's put "lady doctor" to rest, as well. Don't call her "Madam." Just call her "Doctor."

## PRESIDENT'S LETTER

# Rx drug costs – out of sight, out of mind

By Arvind K. Goyal, M.D.



*"Fewer and fewer insurance companies and employers cover prescriptions."*

A man walked in a pet shop, pointed to a big dog, and inquired, "How much do you want for that?" "One hundred dollars," responded the clerk. "And how much for that small fellow over there?" was the next question. "A hundred seventy-five" was the answer. "And for that tiny one?" "Just three hundred," the clerk replied. The customer looked puzzled. "How much," he finally asked, "will it cost me if I don't buy a dog at all?"

Not funny! These days, in drug stores, many of our patients are asking similar questions. The rising price of prescription drugs, many of my patients tell me, is forcing them to consider quitting medications – some prescribed for life-threatening conditions. A recent General Accounting Office study found that the prices of 19 out of 29 most commonly sold prescription medications in the United States increased by more than 100 percent in the past six years, a rate much higher than that of general inflation and the cost of medical care. The federal government complains it paid \$22.80 for 1,000 capsules of Dilantin 100 mg. in 1985, and \$102.30 for the same in 1991, a 348.7 percent increase. My patients pay \$135 for the same at a drug store, even more if the prescription is dispensed by a hospital-based pharmacy. Everybody, I know, is extremely concerned about health care costs in general. Fewer and fewer insurance companies and employers now cover prescription medications.

Some of these rising costs reflect the effects of liability insurance in our sue-happy society – the makers of Bendectin, Dalkon Shield, and Tylenol would confirm that! It must cost to comply with ever-increasing bureaucracy there too, including such items as paper work, inspection, packaging and labeling requirements, etc. The cost shifting that occurs from doing discounted business with government and HMOs must have its effect, as well.

The drug manufacturers who produce and profit from this business will tell us that new product research is not cheap. "Guinea pigs" are expensive as gold! And the approval process – going through the fire of the FDA without getting burned is not for sissies! It must take lots of luck, skill and resources to start from scratch and develop "miracle" drugs able to kill the smartest of germs, eliminate cancer cells, dissolve clots and postpone labor. It appears, however, the price labels reflect not just the actual costs plus rea-

sonable profits, but the most the market will bear! The tax credits, the grant monies and other public contributions must reflect even in the initial pricing of new drugs. Once the research, development and initial marketing costs have been recovered, in all fairness, the costs of new medications should come down, but that never happens! Research for development of future experimental drugs to treat AIDS, cancer, and Alzheimer's disease, etc., if funded by using revenues from drugs already on the market, has the potential of unlimited and illegitimate cost hikes!

Another practice, that of marketing long-acting or other variants of existing brand-name medications a year or so before their patent expires, serves to protect the high market price for a brand name while the much cheaper generic versions become obsolete even before they are introduced. Media reports of generic scandals and lack of quality control practices in recent years have added to the eroding confidence of many physicians and public alike in generic medications.

Recent media reports of expensive gifts, vacations and cruises provided by drug companies to some physicians, and other abuses have helped fuel the indictment by some: Could that be why patients pay more for their prescriptions? We may just be too close for comfort! Since prescriptions for effective medications are written by caring physicians and filled by well-meaning pharmacists, we, in the eyes of many, become a part of this price-gouging system. AMA guidelines for gifts to physicians from industry, guidelines for commercial participation in CME, and recent programs by some drug companies for provision for free prescription drugs to indigent patients will help little in clearing that smeared image. The price of greatness, they say, is responsibility.

Something more than just "window dressing" needs to happen here – and quickly. Those business forces that dictate the prices of many commodities and services in the marketplace cannot be allowed to interfere with health care for our people. Health care in general and prescription drugs in particular must remain available and affordable for everybody. What is possible, remains our highest duty!





"I'll level with you ... You're sick as a dog!"

## LETTERS

### National health referendum

In Cook County, the November ballot will include, in my opinion, a meaningless referendum. The voters will be asked to endorse the concept of publicly financed national health insurance.

The trouble is, the question is not do we want everyone to have access to quality health care? That answer is yes. The more compelling question is how do we pay for it? The framers of this referendum failed to tack that on.

By anyone's estimate, such a program will call for major tax increases. And another government bureaucracy. There is no question that the health care system in this country is in serious trouble. It costs too much. Employers are having to cut back on employee benefits, and individuals and families cannot handle the burden on their own.

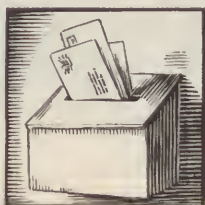
Universal health care is certain to be one of the priority issues in Congress and the state legislatures in the foreseeable future. While this referendum will give us a reading on how receptive the people of Cook County are to universal health care, it will be a hollow verdict because the larger question of the taxpayers' willingness to dig deeper into their pockets to pay for it was left out.

— Sen. Judy Baar Topinka  
22nd District

### Date of death incorrect

Your latest magazine reports an error. Dr. Nesbitt of Elgin expired sometime in early 1977, or 15 years ago. I was at that time at a medical meeting in Sarasota, Fla., and upon my return I was informed that she had expired at St. Joseph's Hospital and was already buried.

I knew her personally. She was married to Werner Tuteur, M.D., with whom I worked for some 20 years at the Elgin State Hospital.



They both lived at 162 S. State St. in Elgin, where they had private offices. For practical reasons she had retained her own name.

Are you so far behind with reporting, or is there a mistake? I am sure that the county clerk or the recorder of St. Joseph's Hospital in Elgin would corroborate that she died there about 15 years ago.

— Rochus Stiller, M.D., Elgin

*Editor's response: Dr. Stiller refers to the obituary for Marjorie R. Nesbitt, M.D., that appeared in the Aug. 14 issue of Illinois Medicine. Dr. Nesbitt's date of death was listed as Jan. 10, 1992. Dr. Nesbitt's family has informed Illinois Medicine that her actual date of death was March 30, 1978. The Society receives membership data, including death notices, from a variety of sources. In this instance, the information provided to Illinois Medicine was incorrect; we regret any unhappiness this may have caused Dr. Nesbitt's family and friends.*

### Comments on redesign

I used to scan *Illinois Medicine*, then toss it. No more. I now read it word for word. It's become a "must" read. The new design also makes it an efficient and pleasant task. Kudos on your superior reporting and clean and classy style.

— Paul C. Gerber,  
Physician's Management  
Naperville, IL

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## GUEST EDITORIAL

# Controlling costs through competition

Some lawmakers, it seems, have already made up their minds. Many in Congress think a system of mandatory and binding rates for physician services is the best way to control rapidly rising health care costs. As a result, proposals to mandate so-called "all-payer" rates are now part of larger health care reform bills in both the House and the Senate.

Government price-fixing has never worked in controlling costs for any goods or services. Those who continue to propose government price-fixing as a way to control America's health care costs are shutting their eyes to the lessons of history. The American Society of Internal Medicine has offered an alternative that meets the legitimate cost concerns of health care while maintaining the physician-patient relationship and quality of care.

ASIM's alternative to government all-payer rate setting would create a competitive market for both physician services and health insurance. The proposal is based on fundamental economic principles and is predicated on the belief that true market forces are more effective than regulation in controlling costs.

Under ASIM's plan, all payers — public and private — and physicians would be required to use a uniform method, the resource-based relative value scale (RBRVS), to set payment and charge schedules. In calling for use of the RBRVS, ASIM is not advocating an extension of Medicare to the private sector. The RBRVS methodology would be adopted but without the limiting charges or geographic adjustments.

With the RBRVS in place, each private insurer would establish its own single conversion factor on an annual basis. The conversion factor, when multiplied by the RBRVS, would create the maximum charge schedule for each plan that the insurer offered to purchasers. Likewise, each physician would also set a single conversion factor on an annual basis that, when multiplied by the RBRVS, would create the maximum charge schedule for all services rendered by the physician.

To create true competition, which would, in turn, control costs, full disclosure of the conversion factors of all insurers and physicians would be mandatory. For the first time, insurers would know what other insurers would pay, physicians would know what other physicians charge, and consumers would have all of the information they need to make cost-conscious choices about their health care insurer. Insurers might publish the conversion factors for physicians to create a simple means of comparing physician charges.

Patients, or consumers, would be able to determine

costs of care in advance by comparing the conversion factor of their insurer to that of their chosen physician. As a result, patients would be spared the "sticker shock" they now experience when they get a bill they think is too high and a reimbursement they think is too low.

By setting their own conversion factor, physicians would be able to establish their own fees based on their own individual practice needs and assessments. Those physicians with higher conversion factors would have to prove their worth or face the prospect of losing patients to another physician who could provide the same or a better level of service for a lower price. Similarly, competitive pressures would force insurers to offer better deals to employers and other purchasers in terms of premium costs, out-of-pocket expenses and availability of services. The marketplace would drive payments and charges for physician services to the lowest rate that met the needs of the patients in each community.

The conversion factor and geographic adjustments for this plan would be established through negotiations between the government and the medical profession, under the auspices of an independent board. Costs for the public plan would be kept in line by negotiating expenditure goals, not caps. Costs for health care for the poor and those who have no choice of a physician (those needing true emergency care, for example) would be controlled by balance billing limits.

With the nation's health bill expected to double by decade's end, the need to control costs has taken on a new urgency. Recently, a *Journal of the American Medical Association* editorial predicted that within the next five years Congress will take drastic action, perhaps even nationalize the entire health care system, if costs continue to rise at an unsustainable rate.

If we are to preserve the current multiple-payer system, we must show policymakers that the system can be retooled to work with greater efficiency. We must come to the table with proposals, like ASIM's, that promote cost control through competition rather than by coercion or mandate. It is not too late to head off all-payer legislation and other heavy-handed regulatory remedies, but the time to promote a workable alternative is now.



**Ronald L. Ruecker, M.D.**, a Decatur internist, wrote this letter as a member of the Board of Trustees of the American Society of Internal Medicine. He also serves as a member of the ISMS Board of Trustees.

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# ISMIE Update

## Case in Point looks at back surgery

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## Physicians sued for malpractice should heed litigation 'don'ts'

**MALPRACTICE:** If you are sued, do not alter records or discuss your suit beyond your defense attorney and malpractice insurer. By Tony Sullivan

[ CHICAGO ] David Hall, a malpractice defense attorney with Lord, Bissell & Brook in Chicago, recalls the case of a pediatrician who treated a child in his office for cold-like symptoms. The child later contracted meningitis and died, and the family sued the physician. To "protect" himself, the physician dictated a separate set of medical records that described the medical management he allegedly provided for suspected meningitis. When the plaintiff's attorney uncovered the dual records during the formal discovery process, the pediatrician's fate was sealed.

Altering the original medical records of a patient who has brought suit is arguably the most devastating and damaging mistake physicians can make when they are sued for medical malpractice, said Hall. "Altered medical records can affect the outcome of a case probably more than the underlying medical facts. Even if the doctor complied with the standard of care, if he or she significantly altered records, the jurors will likely not believe anything the

*"Talking to  
patients often  
gives plaintiffs'  
attorneys more  
information to  
use against  
you."*

ALFRED J. CLEMENTI, M.D.

doctor has to say in his or her own defense. They will be looking for any excuse to hit him or her with an award." A good plaintiffs' attorney will make a "big deal" out of changed records, said Hall, and the records, not the patient's care, will become the focus.

Altering records is one of several important "don'ts" physicians should keep in mind if they're sued, advise malpractice defense experts. What a physician does, particularly in the hours and days immediately

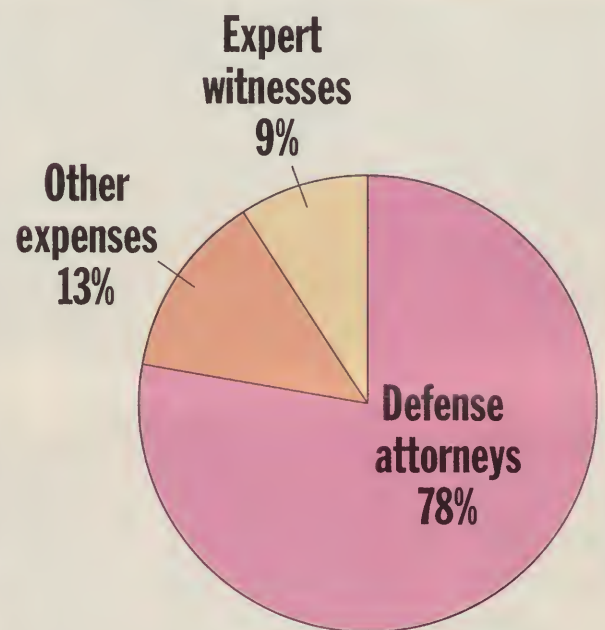
after receiving a summons, can be critical to the successful defense of the case. Making the right moves might mean a quick summary judgment in the physician's favor. Making the wrong moves, however, could result in a high-ticket verdict for the plaintiff.

If no suit has been filed, talking to the patient or family may be in order, said Alfred J. Clementi, M.D., a member of the Illinois State Medical Insurance Services Board of Directors and a general surgeon from Arlington Heights. In fact, that step could discourage patients from filing a lawsuit. But if a patient has filed suit, mum's the word.

Physicians involved in a malpractice lawsuit, however, should avoid talking with the patient or family members who filed the suit, Dr. Clementi said. "Physicians have to avoid [acting on] the feeling that if they could just explain things to the plaintiff, they could change their minds about filing a lawsuit."

The best course is to say nothing to patients and family

### Attorney fees make up three-fourths of defense costs\*



\* Based on results of 78,712 claims of the PIAA Data Sharing Project, accumulated between Jan. 1, 1985, and June 30, 1991. This is not a statistically valid survey based on random-sampling techniques.  
Source: Physician Insurers Association of America

members. "We discourage [physicians] from trying to explain away or trying to give reasons why certain treatments were used or procedures done," Dr. Clementi said. "Talking to patients often gives plaintiffs' attorneys more information to use against you."

**MAINTAINING SILENCE** is particularly important when it comes to discussions with peers about a case. Specifically, physicians involved in a lawsuit should not talk about a case with "subsequent treaters" — other physicians who provided care to the patient after the alleged adverse event, Dr. Clementi said. The opinion of subsequent treaters can strengthen the defense of a malpractice case, but subsequent treaters who have discussed the case can be precluded from testifying under the "Petrillo rule."

*Petrillo vs. Syntex Laboratories Inc.*, an Illinois Appellate Court decision rendered in the mid-1980s, specifically held that it's improper for defense attorneys to contact subsequent treating physicians to discuss anything about the defendant physician's care and treatment

of the plaintiff. The court further held that if defense attorneys do discuss the case with a subsequent treating physician without the opposing attorney in attendance, the physician could be barred from testifying.

"That decision had significant practical impact on [defense attorneys] because now we need to depose these people, which takes a lot of time and money, to get the information we want," Hall said. "We can't simply call them up to determine whether it will be worth the time and money to depose them. The courts are allowing us to get the information we want. We just need to jump over a few more hurdles to get it. They think that somehow protects the plaintiff more."

Many cases have arisen from the *Petrillo* decision. "It has been a heavily litigated area in our field," Hall said. "With their subsequent decisions related to *Petrillo*, the courts are extending the limitations to prevent any conversations between the treating doctors and defense attorneys. For example, they don't want us sending these

(Continued on page 11)

## MALPRACTICE ROUNDUP

### Advice or consultation?

The *Malpractice Reporter* recently discussed whether a colleague of the treating physician creates a physician-patient relationship by offering advice on a patient. The question arose in a suit in which an infant was admitted to the neonatal intensive care unit for extreme jaundice and high bilirubin level.

The infant's physician

sought the opinion of another physician, who advised the infant's physician to wait for test results before performing an exchange transfusion and to "get back to him" if the situation changed. The infant's physician considered this to be a consultation, but the defending physician did not, claiming that 90 percent of consultations at the hospital followed a procedure involving written orders. The defending physician stated he did not examine the infant, or

look at his chart or any test results.

The plaintiff alleged the infant suffered brain damage and other injuries that would have been avoided with a timely diagnosis and exchange transfusion. Summary judgment in favor of the consulting physician was affirmed on appeal because the advice and invitation for further discussion were too general to support the claim that he had participated in the infant's care and treatment. ■



## Case in Point

*A regular feature using hypothetical case histories to illustrate loss-prevention maxims.*

By Carol Brierly Golin

### Case #1

**Presenting complaint and initial diagnosis:** A 37-year-old man was referred by his family physician to a neurologist for treatment of back pain.

**The case in brief:** When the patient's condition failed to improve after three months of conservative treatment, he was admitted to a hospital, where a myelogram produced unclear results. The neurosurgeon diagnosed a probable ruptured disk and recommended surgery. A lumbar disk was removed, but no rupture was evident, and the patient's back pain still did not improve. Several months later, another myelogram and a CT scan were performed, neither revealing a definitive clinical cause of the pain. The neurosurgeon recommended a second operation to remove another possibly ruptured disk. No rupture was found during surgery, after which the patient was severely disabled. He could not lift heavy items or return to his job. He experienced back and leg pain, which hindered his ability to sit, stand, walk and sleep.

**The resulting claim:** The patient sued for unnecessary surgery and for failure to diagnose his problems appropriately.

**The outcome of the claim:** The defendant physician contended that, although

the clinical indications of ruptured disks were questionable, it was reasonable to conclude that ruptured disks were causing the man's back pain. A jury awarded \$500,000 in damages.

### Case #2

**Presenting complaint and initial diagnosis:** A 33-year-old woman experiencing back pain saw an orthopedic surgeon who diagnosed a herniated disk at L5-S1.

**The case in brief:** The surgeon operated but removed the disk at L4-L5. The woman's back pain continued. Six months later, she saw another surgeon, who diagnosed the L5-S1 disk on physical examination and subsequently removed it. The plaintiff experienced immediate pain relief.

**The resulting claim:** The patient sued the original surgeon for operating at

the wrong level and for pain and suffering.

**The outcome of the claim:** Plaintiffs' experts testified that removing the wrong disk was negligent and that an intraoperative film should have been taken if there was any question about the disk location. The case was settled for \$80,000.

### Case #3

**Presenting complaint and initial diagnosis:** A 15-year-old girl with progressive scoliosis was referred to an orthopedic surgeon for surgery.

**The case in brief:** The surgeon performed a spinal fusion using three Harrington rods from T3 to L4 with autogenous iliac bone grafting. The surgery was uneventful, but the girl was slow to awaken in the recovery room. When she

did, she had no sensation in her lower extremities. She was returned immediately to surgery, and the rods were removed. The outcome was T4 paraplegia.

**The resulting claim:** A suit was filed alleging negligent performance of the procedure and failure to use tests during the surgery that might have detected developing problems.

**The outcome of the claim:** The surgeon contended that the procedure was properly done but that the risk of paraplegia always exists in such cases, often for unknown reasons. He said he believed the paralysis resulted from a vascular accident. He also noted that at the time of the surgery, somatosensory evoked potential (SSEP) equipment was not readily available for use in spinal surgery. However, in a letter to another treating physician, he said that perhaps he had used too much distraction in the procedure. The jury awarded \$800,000.

**The points these cases make:** Back surgeries sometimes are performed without enough clinical documentation of pathology, said Luis Yarzagaray, M.D., assistant professor of neurosurgery at Loyola University, and a former member of the Illinois State Board Medical Examining Committee and the Illinois Medical Disciplinary Board.

But when a patient is in severe pain after conservative treatment, a surgeon might reasonably deduce that surgery is in order even with a negative myelogram or a questionable MRI or CT scan, he said. Nevertheless, if surgery is performed when tests are normal, resulting claims could be indefensible.

The decision to operate should be based on documented test results that reveal pathology — evidence with which other surgeons would concur, Dr. Yarzagaray emphasized. Or, it should

be clearly explained to the patient that the procedure will be exploratory, with no guarantees attached. He also suggested that to minimize potential liability, exploratory surgery should be supported by careful physical examinations and the patient's own history, including nurses' notes and observations.

Operating at the wrong level of the spine "happens more often than we wish," Dr. Yarzagaray said. Also, if the retractor moves slightly, a surgeon can unknowingly be in the wrong space. Sometimes the intraoperative x-ray may distort the position of the needle because of the positioning of the patient and the operating table.

"A surgeon who finds nothing at what is fully believed to be the right level should repeat the intraoperative x-ray. Check and check again to make absolutely sure the location is right," he said.

If the surgeon had not written that he might be partly responsible for the bad outcome, Case #3 might have been defensible, given the possibility that a 15-year-old might develop paraplegia as a result of the scoliosis procedure, Dr. Yarzagaray said. He advised using SSEP intraoperatively. "In many cases, you might prevent a catastrophe if you do so."

To minimize liability arising from back surgeries, Dr. Yarzagaray recommends these precautions:

- Operate only when there is clear documentation of pathology. Evidence of pathology should be obvious to other physicians and surgeons.
- Use judgment and obtain patient permission for an exploratory procedure when test results are questionable but a patient still has pain. The patient should fully understand that there are no guarantees.
- Avoid operating at the wrong space by using all appropriate technology, including intraoperative x-ray and a light-dissecting microscope. "The microscope

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- If you don't have a specific employee name to give the operator, specify which department you need (see below); this will prevent your call from being repeatedly transferred. You DO NOT need to have your policy number.
- If you are not sure what department you need, ask for policyholder relations. Every member of the policyholder relations staff is trained to answer your questions or direct you to the department that can.

We want you to contact the correct department. Although you may have talked previously with a particular employee, he or she may not be able to answer your immediate question. For example, if you have previously spoken with a particular claims analyst but you are calling because you need a loss history, you should ask for policyholder relations, not the claims analyst. Your call will be handled more efficiently when directed to the correct department. Of course, every ISMS employee is eager to help you no matter what your concern. The following chart will be helpful for doctors and staff in making a quick connection.

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will help you recognize if indeed there is a disk herniation," Dr. Yarzagaray said. "If the patient later presents with pain, you should consider repeating the myelogram." After comparing the needle position with the myelogram and MRI to ensure correlation, compensate for any possible distortion of the needle position caused by the intraoperative x-ray, he said. If there is any question, "repeat these checks to the point of exhaustion before removing the disks."

- Use SSEP as a continuing indicator of possible developing problems.

- Videotape procedures when appropriate.

- Keep abreast of the latest techniques

and learn how to use new equipment.

- Be honest with yourself about the necessity for and appropriateness of doing any surgical procedure and be honest with your patients about the procedure's potential risks, advantages and disadvantages, as well as other options.

"Physicians and surgeons are human, and we do make mistakes," Dr. Yarzagaray said. "However, it is our personal responsibility to do everything we can to avoid them." ■

Carol Brierly Golin is publisher of Medical Liability Monitor.

## EXCHANGE Q & A

**Q: If I receive a letter from a lawyer asking to take my deposition, should I notify my insurance company?**

**A:** Contact the Exchange before responding to *any* correspondence from a lawyer regarding your care of a patient. Your Exchange policy protects you by providing advice and, if necessary, legal representation to evaluate the possibility of being named in a lawsuit.

**Q: How can I obtain coverage for practice in a surgicenter?**

**A:** Determine whether the center has been approved by the Exchange as a practice location. Surgicenters seeking approval should complete application forms from the Exchange. Surgicenter personnel complete the forms and forward them to ISMIE. Once the Exchange has evaluated the surgicenter as a practice location, the physician is notified.

## Malpractice 'don't's'

(Continued from page 9)

doctors materials about the case without the other side's knowing about it."

Initially Petrillo just kept physicians from telling the defense attorney anything about the patient's care and condition and conversations with the patient. "Now it's gone further, to prevent other people from telling the doctor things that don't even violate a patient-physician confidence," Hall said. The courts fear that defense attorneys will somehow sway the opinions of subsequent treating physicians, so they have extended Petrillo to all sorts of interaction and conduct between the defense counsel and nonparty treating physicians, according to Hall. "It's to the point that any type of unilateral contact is at risk."

There are no such limitations on discussions between a defense attorney and the defendant physician, noted Hall. In fact, defendant physicians should supply the attorney and claims manager with as much key information about the case as possible, he advised. They also should guide defense attorneys on questions to ask subsequent treaters and expert witnesses during depositions to make sure the salient medical facts emerge, added Dr. Clementi.


**DEFENDANT PHYSICIANS** should limit discussions about the case to the claims department of the malpractice insurance company and the defense attorney, said Dr. Clementi.

Another "don't" is blaming other providers, said Hall. "We like to have a unified defense between defendants. If the defendants get into a finger-pointing episode, it makes the defense very difficult, and it tends to increase the likelihood of an adverse outcome for all defendants involved in a lawsuit."

Physicians also should thoroughly familiarize themselves with medical literature related to the care they provided, said Dr. Clementi. This identifies and documents the standard of care when they treated the patient and provides an objective benchmark against which to compare the care they provided.

In addition, physicians should gather all medical records related to the case and keep them under their or their attorney's control at all times, malpractice defense experts advise. Physicians also should be sure to keep all correspondence to their insurer, defense attorney and personal attorney (if involved in the case) separate from the medical record, in a confidential file. ■



  
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## WOMEN IN MEDICINE MONTH

# Freethinking firsts

## Illinois' vanguard women physicians



BY ANNA BROWN

**T**hroughout its history, the state of Illinois has produced great physicians and medical institutions, both of which have made indelible contributions to the medical sciences. The mid- to late 19th century was an especially rich period in medical advancement in Illinois and the United States, when women began to conquer enormous opposition to obtain medical education and training. By the end of the century, 7,000 women physicians were practicing in the United States.

Today, women physicians make up 16.7 percent of the members of the Illinois State Medical Society. Of 284 ISMS House members, 39 women are delegates, and of Illinois' 41-doctor American Medical Association delegation, seven women are members. Medical school enrollment indicates that these numbers should continue to increase. The perseverance of Illinois' female medical pioneers gradually led women physicians to their current status of practicing equally alongside their male colleagues, although their numbers are concentrated within a small number of specialties, mostly gynecology, pediatrics, internal medicine and psychiatry.

From Mary Bates, M.D., the first woman intern at Cook County Hospital, to Bertha Van Hoosen, M.D., founder of the American Medical Women's Associa-

tion, Illinois women physicians overcame discrimination to obtain equal training within their specialties. They broke ground in organized medicine, wrote highly regarded clinical essays and founded hospitals and medical schools to further their knowledge. The five physicians profiled below represent a cross section of the women physicians who helped shape the history of medicine in Illinois.



Mary Harris  
Thompson, M.D.

### Mary Harris Thompson, M.D.

In 1863, Mary Harris Thompson, M.D., came to Chicago from Boston, where she graduated from the New England Female Medical College. Her first medical efforts in Chicago involved serving widows and orphans during the Civil War. Recognizing that Chicago lacked adequate medical facilities, especially for women and children, she founded the Chicago Hospital for Women and Children in 1865, with the support of William H. Byford, M.D., and her colleagues in the war effort, William G. Dyas, M.D., and his wife Miranda Dyas. Dr. Thompson served as the hospital's head of medical and surgical service until her death in 1895.

Dr. Thompson and Dr. Byford formed the core of a committee dedicated to women in medicine, which opened the Woman's Hospital Medical College in 1870. Despite a serious lack of funds and equipment, professors were recruited from around the

### Illinois women's early strides into medicine

- 1830** – Lura "Grandma" Guymon serves as doctor and midwife to Native Americans in the Danville area.
- 1841** – Sarah Hackett Stevenson, M.D., is born.
- 1852** – Emily Blackwell is denied permission to complete her medical studies at

Rush Medical College after ISMS censures the school for impropriety in admitting women.

- 1860** – Lucy Waite, M.D., is born.
- 1865** – Chicago Hospital for Women and Children is founded by Mary Harris Thompson, M.D.; William H. Byford, M.D.; William G. Dyas, M.D.; and

Miranda Dyas.

- 1866** – Letitia Westgate, M.D., is born.
- 1869** – Hahnemann Homeopathic College becomes the first medical school in Illinois to admit women.
- 1870** – Woman's Hospital Medical College of Chicago opens.
- 1871** – The original building of the Woman's

Hospital Medical College of Chicago is destroyed by the Great Chicago Fire.

- 1872** – Isabella Maude Garnett Butler, M.D., is born.
- 1875** – Dr. Stevenson chairs the ISMS Committee on Progress in Physiology.
- 1876** – Dr. Stevenson becomes the first woman delegate to the AMA.



# WOMEN IN MEDICINE MONTH

city, several of whom were connected with the Women and Children's Hospital. After being denied admission to Rush Medical College, Dr. Thompson received a second medical degree from the Chicago Medical College, and taught clinical obstetrics and diseases of women at the WHM College.

Although the original building for the WHM College medical school was destroyed in 1871 by the Great Chicago Fire, the Woman's Medical College, as it was renamed in 1879, continued to grow. That year, the senior class was invited to sit for the examination for admission into the internship program at Cook County Hospital. A WMC student, Marie J. Mergler, M.D., reported that at the time, the women were not adequately trained in the field of surgery because some WMC professors felt surgery was beyond women's capabilities. Eventually attitudes changed, and in 1881, Mary Bates, M.D., became the first woman intern at Cook County Hospital.

In 1891, WMC became a department of Northwestern University under the name Northwestern University Woman's Medical School. The university closed the Woman's Medical School in 1902. Dr. Mergler speculated that it closed for financial reasons, since she believed that the institution's reputation in the medical community remained extremely high. By that time, all other medical schools in the city had become coeducational.

## Sarah Hackett Stevenson, M.D.

A graduate of and eventually professor of physiology at the Woman's Medical College of Chicago, Sarah Hackett Stevenson, M.D., opened the doors of organized medicine to women. Born in 1841 in Ogle County, Dr. Stevenson attended Illinois State Normal University and began her professional life as a public school teacher and principal. When her interests turned to scientific writing, she enrolled at WMC, where she discovered her love for medicine and began her studies in anatomy and physiology. To broaden her education, she made several trips to Europe, studying with Thomas Huxley and Charles Darwin. Then Dr. Stevenson returned to Chicago to practice and teach.

In 1875, Dr. Stevenson joined ISMS, where she chaired the Committee on Progress in Physiology. Her efforts led ISMS President T.D. Fitch, M.D., to appoint Dr. Stevenson an alternate delegate to the 1876 American Medical Association annual meeting in Philadelphia when one of the Illinois delegates fell ill.

Upon hearing Dr. Stevenson's name during the roll call at the meeting, a Michigan delegate moved that the names of female delegates be referred to the Judicial Council. In the discussion that followed, delegates recalled spending much time previously debating whether African-American and women physicians could attend AMA meetings. AMA President J. Marion Sims, M.D., resolved the question in his address to the House of Delegates: "The Association [is] a truly representative body and ... if any state

or county medical society should send as a delegate either a woman or a Negro, the Association [is] bound to receive the delegate."

David J. Davis, M.D., Ph.D., wrote in the *History of Medical Practice in Illinois* that Dr. Stevenson did not address the House during that first meeting, perhaps wisely. She did, however, present a paper to the ISMS House of Delegates that year in Urbana.

In addition to her work in organized medicine, Dr. Stevenson adopted many social causes, including working for the Jane Addams Hull House and successfully lobbying for the Chicago Women's Club to admit its first black member. She died in 1909.

## Lucy Waite, M.D.

Through her research as a gynecologic surgeon and her extensive writing, Lucy Waite, M.D., achieved recognition for women in medicine and in American society. Born in 1860 in Chicago during the period when Dr. Thompson founded the Chicago Hospital for Women and Children, Dr. Waite would later succeed her as chief of staff at the hospital, renamed the Mary Harris Thompson Hospital upon the founder's death.

In writing about Dr. Waite, William K. Beatty, professor of medical bibliography at Northwestern University Medical School, said that she strove to further understanding of women's health issues by denouncing unnecessary surgery for women and exposing myths in the field of gynecology. "We are rapidly becoming a nation of scars," she said in one of her numerous lectures throughout the world. Gynecological superstitions of the late 19th century often centered on the "correct" position of the uterus. Although physicians used a variety of surgical methods to "reposition" the uterus, Dr. Waite advised her peers to ask three questions before undertaking any surgery: Are these operations necessary? Are they safe surgical procedures? Have they proven successful in a sufficiently large percentage of cases to warrant their continuance?

Her first publication in 1891 was a novel depicting the lives of two female physicians who question women's traditional roles in society. Characters proclaim their amazement in meeting the women physicians and address fears that such women seemed to be "monstrosities."

Her later clinical articles appeared in various scientific journals, including *The American Journal of Surgery and Gynecology* in 1899 and *Modern Gynecology* in 1901. She wrote a five-page biographical sketch of Dr. Thompson in 1904. Her writings and lectures addressed many aspects of surgery, including the possibilities of mental healing and the implications of shock. She also debated the merits of vaginal vs. abdominal hysterectomies and, from her surgical successes, determined that the "removal of the uterus holds out to the patient the greatest hope of restoration to health and strength. And moreover to the surgeon it promises a



Lucy Waite, M.D.



Sarah Hackett Stevenson, M.D.

- 1877 - Dr. Stevenson joins the staff of WHMC as corresponding secretary and professor of physiology.
- 1879 - WHMC is renamed the Woman's Medical College. For the first time, its seniors are invited to Cook County Hospital's internship examinations.
- 1881 - Mary Bates, M.D., becomes the first

- woman intern at Cook County Hospital.
- 1883 - Dr. Waite receives her first medical degree from Hahnemann Homeopathic College.
- 1890 - WMC enrolls 152 students.
- 1891 - WMC affiliates with Northwestern University. It becomes the

- Northwestern University Woman's Medical School.
- 1892 - Dr. Westgate receives her medical degree from the NU Woman's Medical School.
- 1894 - NU Woman's Medical School has 350 alumnae.
- 1895 - Dr. Waite receives her second medical

- degree from Harvey Medical College. Dr. Thompson dies. The Hospital for Women and Children is renamed Mary Harris Thompson Hospital. Dr. Waite becomes its chief of staff.
- 1898 - Rush Medical College opens to women after affiliating with the University of Chicago.



## WOMEN IN MEDICINE MONTH

peace of mind and immunity from future torment which the removal of ... diseased appendages alone can never offer."

For the Christmas 1897 issue of the *Medical Herald*, Dr. Waite wrote an article titled "Women in the Medical Profession." In it, she described her visits with women physicians around the world and expressed optimism about women's future role in medicine in the United States. She suggested reasons why women were not leaders in scientific thought at that time: "This consciousness of being watched, of having her every action made a pro and con in the great argument has made her timid, and together with her natural conservatism, has made her a follower instead of a leader in scientific thought," she wrote. "When the mere fact of holding a medical degree makes her eligible to every medical institution and society in the land ... she will not be found wanting in scientific investigation and original research."

**Isabella Maude Garnett Butler, M.D.**

In 1901, when Isabella Maude Garnett Butler, M.D., graduated from the Physicians' and Surgeons' College, now the University of Illinois College of Medicine, she became one of the first African-American women physicians in the state. Born in 1872, Dr. Butler was the first African-American to graduate from Evanston Township High School. She attended business school and then studied nursing at the Provident Hospital Nurses Training School.

"I took up nursing to work my way through school," Dr. Butler told a reporter in 1938. "But I knew I wanted to be a physician and have my own hospital some day."

When Dr. Butler began her medical career, African-American physicians and patients were barred from most hospitals. Evanston, like many communities, had no hospital serving African-Americans.

With money from their private practice, Dr. Butler and her husband, Arthur D. Butler, M.D., opened a health center for African-Americans on the upper floor of their home in Evanston in 1914. Known as the Evanston Sanitarium, the 14-bed center was for many years the only institution between Chicago and Milwaukee to freely admit blacks.

After her husband's death, Dr. Butler raised enough money through the Booker T. Washington Association and the Evanston Interracial Council to open the 28-bed Community Hospital of Evanston in 1930. Although the hospital struggled through the Depression years and physicians often worked for free, the hospital existed until 1980, when it was converted to housing for the disabled. Dr. Butler remained hospital superintendent until her retirement in 1945, three years before her death. In 1975, a 16-acre park adjacent to Community was dedicated in her honor.



Letitia Westgate, M.D.

**Letitia Westgate, M.D.**

The first hospital in DeKalb County was opened by the 1885 valedictorian of Mendota High School, Letitia Westgate, M.D. Born in LaSalle County in 1866, Dr. Westgate attended Knox College in Galesburg and graduated with honors from what was most likely the Woman's Medical School at Northwestern University before setting up practice in Sycamore, 60 miles west of Chicago.

She first opened the Sycamore Surgical Hospital as an emergency hospital and charged each patient \$5 per week. As Rosanne Krcek Frank wrote in her 1977 article on Dr. Westgate for the *Journal of the American Medical Women's Association*, the hospital provided steam heat, electricity, city water, telephones, janitorial service, and linens and towels. However, it was not the "modern" hospital she thought the county needed.

In 1898, Dr. Westgate began fundraising for a new hospital, forming a stock company to sell 500 shares at \$10 each and pledging to rent the new building for 10 years. Unfortunately, Sycamore was not yet ready for such an "unfeminine" approach to medicine and business.

She managed to fund the new hospital, which opened in 1900, but Dr. Westgate was plagued by vandalism and rumor that she had killed a patient. She went to court to clear her name in a slander trial against two women who had started the rumor. With the support of the local press and expert testimony by her colleagues, Dr. Westgate proved that she had not given a patient an overdose of morphine but that the patient had died of "malignant jaundice."

Soon after the case was closed, Dr. Westgate wrote in her diary, "I won my lawsuit, but soon realized that vindication from a jury does not mean a vindication from the public."

After numerous attempts to save the financially ailing hospital, Dr. Westgate was forced to succumb to the lack of community support. In 1907, she moved to Aurora, where she continued to work for women's and children's causes. One of her first projects was tackling the problem of children born to alcoholic parents. She continued to make headlines throughout her life by taking on controversial causes.

Frank wrote of Dr. Westgate's efforts to bring a safe water supply to Aurora and of her fight at age 73 over her research into the cause of 52 inmate deaths at Manteno State Mental Hospital. That battle with the state led her to the conclusion, "Politicians should have no voice in hiring of doctors, nurses and other employees in our state institutions because after hiring them they dominate their conduct. ..." She died within the next few years, still in the public eye.



Isabella Maude Garnett Butler, M.D.

Photos courtesy of the Illinois State Historical Library; The Proceedings of the Institute of Medicine of Chicago; The Evanston Historical Society; and The DeKalb Chronicle Souvenir Edition.

**1900** – Dr. Westgate opens Sycamore Surgical Hospital in DeKalb County.  
**1901** – Dr. Butler receives her medical degree from the Physicians' and Surgeons' College (now the University of Illinois College of Medicine).  
**1902** – Northwestern University closes its Woman's Medical School.

**1904** – Dr. Waite is elected president of the Medical Women's Club of Chicago.  
**1909** – Dr. Stevenson dies.  
**1914** – Dr. Butler and Arthur D. Butler, M.D., open a health center for African-Americans in the upper floor of their Evanston home.  
**1915** – The Medical Women's National

Association is founded by Bertha Van Hoosen, M.D., its first president. It later becomes the American Medical Women's Association.

**1930** – Dr. Butler opens the 28-bed hospital in Evanston that will become the Community Hospital of Evanston.  
**1941** (approx.) – Dr. Westgate dies.

**1943** – Dr. Waite dies.  
**1948** – Dr. Butler dies.

**1975** – Community Hospital of Evanston is dedicated in Dr. Butler's honor.  
**1992** – A historical marker is placed in the Fine Arts Building in Chicago, site of the first AMWA meeting, honoring Dr. Van Hoosen.



*The Illinois State Medical Society Board of Trustees met Sept. 12 at the ISMS Conference Complex in Chicago. Following are highlights of the board's actions:*

#### **ISMS will sponsor free clinic conference**

Nov. 20 is the date for the ISMS-sponsored conference on how communities can address indigent care at the local level. Conference site is the Holiday Inn in Joliet, and the conference will include a tour of the Will-Grundy Medical Clinic. Physicians and county medical society staff are encouraged to attend and to bring leaders from their own community. Registration materials will be distributed in the near future.

#### **ISMS committee to prepare health care reform model**

The ISMS Third Party Payment Processes Committee will use the ISMS Ten Principles of Health Care Reform to develop legislative strategies for health care reform for future legislative sessions. Recognizing that health care reform will be a major legislative agenda item at both federal and state levels, the ISMS Board of Trustees asked the TPPP Committee to deal with the difficult and complex issue of developing a basis for legislation. The board also recognizes that legislation is rarely passed that mirrors what was introduced and acknowledged the risk of introducing its own legislation.

#### **ISMS supports concept of Healthy Moms/Healthy Kids**

ISMS endorsed the concept of the Illinois Department of Public Aid's Healthy Moms/Healthy Kids program, although the board would like further definition of how the program works before declaring its unqualified support. Set for phase-in implementation in April of 1993, the program promises increased funding for medical care for pregnant mothers and children, based on a managed care model. ISMS has been significantly involved in discussions with IDPA since the program was announced and funded. Member physicians have been recommended to advise IDPA in program development.

#### **ISMS to sample Illinois public opinion**

To better serve the ISMS legislative agenda, the board approved a proposed public opinion survey of Illinois voters. This survey will measure public opinion about health care issues and will help structure future ISMS legislative activities.

#### **Seward re-election to AMA board receives unanimous support**

P. John Seward, M.D., a Rockford family physician and first-term incumbent on the American Medical Association Board of Trustees, is supported unanimously by the ISMS Board of Trustees in his re-election bid to the AMA board. The election by the AMA House of Delegates will be held June 16, 1993, in Chicago at the AMA's annual meeting. In a related action, the board also unanimously supported the candidacy of Michael Suk, a UIC College of Medicine at Rockford

medical student, for election as the student member of the AMA Board of Trustees.

#### **Health Care Quality Improvement Act update available**

ISMS will provide hospital medical staff representatives, chiefs of staff and county medical societies with the latest information on the Health Care Quality Improvement Act and the National Practitioner Data Bank. Prepared by ISMS general counsel, the document refines and updates an earlier version prepared in 1988.

#### **ISMS adopts new ACCME standards**

ISMS approved new more stringent standards for commercial support of continuing medical education for programs sponsored by ISMS, as well as those sponsored by other ISMS-accredited organizations. The new guidelines require faculty members to disclose any significant interest or other relationship they may have with a commercial sponsor. ISMS approval of the new standards will help the American Council for Continuing Medical Education work with the U.S. Food and Drug Administration

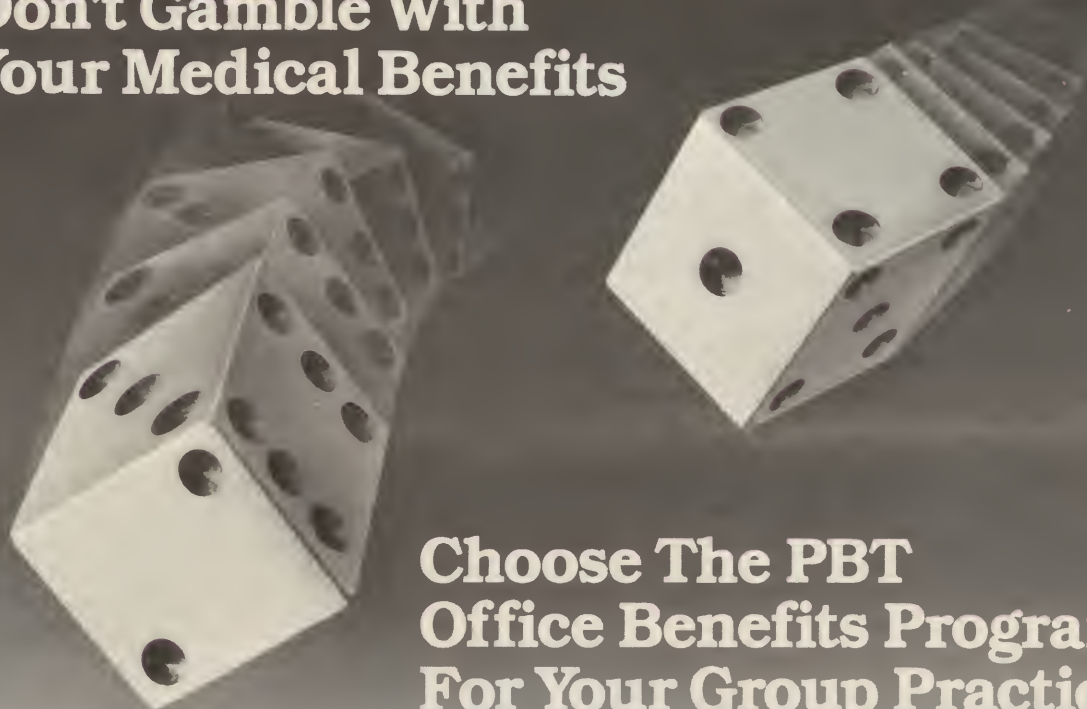
on a voluntary compliance program, as opposed to federal regulation.

#### **Student loan fund expansion approved**

Five slots for medical student loans to Southern Illinois University medical students could be available as a result of ISMS' approving expansion of the medical student loan program beyond the University of Illinois. This program, jointly administered with the Illinois Agricultural Association, provides low-interest loans to medical students willing

*(Continued on page 26)*

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# Twelve key Senate races to watch in the November election



*Illinois Medicine* continues its 1992 pre-election coverage, focusing on 12 races for the Illinois Senate that could prove decisive in determining control of the upper chamber. Three Republicans and two Democrats are trying to move from the House to the Senate, while five Republican senators and three Democratic senators are running for re-election. By Kevin O'Brien

7th DISTRICT



## Walter W. Dudycz (I) – Republican

Walter W. Dudycz, a former Chicago police officer, has been a state senator since 1985. He ran unsuccessfully for the U.S. House of Representatives in 1990. Dudycz attributes much of the rise in health care costs to increasing medical malpractice premiums. "One of the major problems that our health care system is facing is the fact that the cost of providing health care is skyrocketing, and much of that is due to some of the malpractice insurance payments that our medical community is faced with. I have spoken to doctors who have left our state because they could not afford the malpractice insurance," he said. With regard to general reform of the health care system, Dudycz said, "I don't believe in socialized medicine. There is a problem in that everyone in the country and the state should be able to have quality medical care, [but] there is no simple answer. "I think my record is clear as far as the issues regarding those in the medical profession," Dudycz continued. "It's no secret that the trial lawyers have targeted me for defeat, and part of the reason they have done so is that I have not been lock, stock and barrel behind their program. I have been more sensitive to the people who have been receiving as well as providing health care, rather than those who are exploiting it."

## James M. McGing – Democrat

Mr. McGing did not return several telephone calls requesting an interview.

18th DISTRICT



## Patrick J. O'Malley – Republican

Patrick J. O'Malley is a businessman and attorney residing in Palos Township. He is an elected member of the Moraine Valley Community College Board of Trustees and serves as president of the Palos Fire Protection District Board of Trustees.

"It's a national problem that must be addressed with national solutions," said O'Malley of health care reform, emphasizing that he was referring to

general health care policy and not advocating a national health care system.

While acknowledging the seriousness of the nation's health care problem, he said, "Am I in favor of any specific proposal that is out there? No, I don't have any specific preference." He said, however, that establishing a single-payer universal health care system "flies in the face of logic."

He also said health care costs could be better controlled by streamlined administrative processes, increased preventive medicine education of Medicaid patients, and caps on noneconomic damages in medical malpractice cases.



## John J. McNamara – Democrat

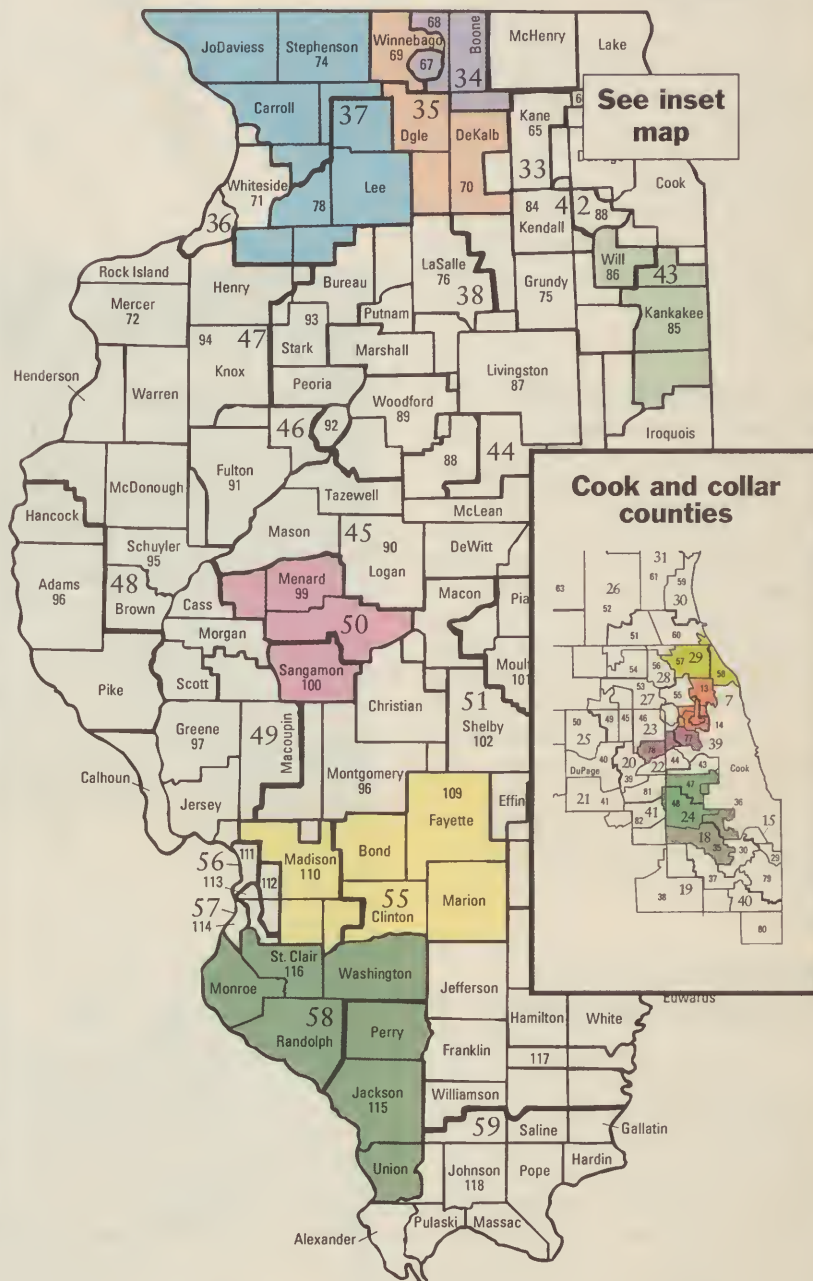
State Rep. John J. McNamara of Oak Lawn, who would like to move up to the Senate, has represented the 27th House District since 1983.

McNamara wants health care reform enacted on a national level but is not convinced that a "single-payer" plan is the best plan. Instead, he advocates a "two-tier program" that permits private insurance for those who can afford it, combined with a gov-

ernment program to cover public aid recipients and the uninsured. McNamara emphasized preventive care as a vital component of any system reform.

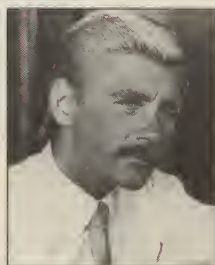
McNamara has "not been one who has been in favor of caps." Instead, he would establish a pre-trial panel of attorneys and physicians to review the merit of potential suits. The panel could say whether or not the suit had merit, or it could remain neutral. No matter what the panel said, the suit could go to trial. But if the panel had ruled the suit had no merit and the plaintiff lost, the plaintiff would be "totally liable for all expenses and fees of the person who they are suing" and for damages payable to the defendant.

## Selected Illinois Senate Districts



Source: Illinois State Board of Elections

24th DISTRICT



## Robert M. Raica (I) – Republican

Sen. Robert M. Raica of Chicago, a member of the General Assembly for about six years, said his work experience provides unique insight into physicians' problems. He has been a paramedic for the Chicago Fire Department for about 16 years. "I have been in favor of tort reform and think tort reform is long overdue," said Raica. "Malpractice insurance is way too high, and a lot of physicians have a hard time even staying in the profession because of the costs they have to incur." Raica does not give tort reform much of a chance in the House. "However, a little brighter light at the end of the tunnel [is that] it would appear that after the election there is a good possibility of the ... Senate becoming Republican, unlike the House. I think the nice thing about it is if we had a Republican Senate, along with our Republican governor, tort reform would be finally dealt with." Raica believes that general health care reform belongs on the national agenda. "If they're going to do anything, they're going to have to do it on the national level; that's my opinion. I really don't have a lot of answers. I can see right now that at almost every hospital throughout the state of Illinois, patients that are seen in emergency [rooms] are patients that should be seen in clinics. ... I think the state has to deal with that type of situation, which affects not just part of the state, but the whole state."

## Anita M. Cummings – Democrat

A letter to Ms. Cummings requesting an interview went unanswered.



29  
th  
DISTRICT



**Roger A. Keats (I) – Republican**

Sen. Roger A. Keats of Kenilworth has been a member of the General Assembly since 1976. He served in the House until he was elected to the Senate in 1979.

A staunch advocate of tort reform, Keats said, "If you think of the medical community as small-business people just like everybody else, you begin to realize it is an issue across the board for everyone."

Although he favors caps, he said they are only part of the solution. "The problem is getting the legal community to accept the fact that there are real-world limits to what a provider – whether a medical provider or a manufacturer – can offer.

"I am not a believer in socialized medicine, and I'm not a believer in a single-payer system," he said. Keats also supports more leeway in administering Medicaid and calls on Illinois public officials to be more aggressive in taking control of the program. "George Bush, Jack Kemp, Louis Sullivan, many of the leaders in Washington have said, 'You give me an experimental model program, I'll OK it.' And what do our people do? They just point fingers at Washington and don't give them ideas."



**Grace Mary Stern – Democrat**

Rep. Grace Mary Stern of Highland Park has represented the 58th House District since 1985 and is running in the 29th Legislative District. Stern, the chief sponsor of the repeal of the premarital AIDS testing bill in 1989, voted against the AIDS notification law and for the Health Care Surrogate Act in 1990.

Like many other candidates, Stern thinks that any resolution of the nation's health care crisis will come from Washington. "I certainly don't think that the answer is a state-of-Illinois-standing-alone general health insurance. I think there will be national health insurance, the medical society notwithstanding."

Stern said the state must address Medicaid's chronic underfunding and late payment problems. "We've got to find more resources." Although Stern does not support caps on noneconomic damages in medical malpractice cases, she said, "I think it is important to present myself as a candidate who tries to evaluate each situation independently. I was there as the chief sponsor of the House bill repealing the premarital AIDS test, which the medical society cared very much about. I can work with the medical society and have in the past."



**Dave Syverson – Republican**

Dave Syverson is a businessman and lifelong resident of the 34th Legislative District, which he hopes to represent in Springfield.

Syverson said that in addition to the high property tax problem, the biggest reason he got into the race is because his opponent co-sponsored the universal health care bill in the legislature.

"We think the current system is fine but needs improvement in a couple of areas," Syverson said. He said the state's Comprehensive Health Insurance Plan (CHIP) should be expanded and means tested. He would fund the CHIP expansion through a premium (tax) on insurance companies. He would also emphasize preventive care for Medicaid patients and try to address the Medicaid funding problem so that providers "especially those involved in family medicine [could] be paid quicker and at a higher dollar amount."

Syverson strongly supports tort reform, including caps on noneconomic damages, although he said he has not decided on a dollar amount.



**Joyce Holmberg (I) – Democrat**

Rockford-born Sen. Joyce Holmberg has represented the 34th Legislative District since 1983. In 1991, she voted for both the AIDS notification bill and the Health Care Surrogate Act.

"I think it's difficult for the state to do a lot," Holmberg said about health care reform. "I think if you're going to have any kind of a general health insurance plan [for the uninsured and underinsured], then you're going to have to look to the federal government so that there's a level playing field. If each state tried to do something, I think we would end up with a checkerboard of values that people will pick and choose from and decide where they want to leave."

Holmberg said she has not decided which of the many reform proposals she would support but she consults with the Winnebago County Medical Society and welcomes its counsel in developing a possible state plan.

Holmberg said she remains opposed to caps on noneconomic damages. She said, however, that she is open to creative suggestions on reforming medical malpractice. She noted that in 1990 she was the chief sponsor of the bill granting physicians immunity for care-giving at community-based free clinics, a measure strongly supported by physicians statewide.

35  
th  
DISTRICT



**J. Bradley Burzynski – Republican**

Rep. J. Bradley Burzynski of Sycamore is another first-term House member hoping to move over to the Senate. Appointed to represent the 76th House District in 1990, he voted for the AIDS notification bill and against the Health Care Surrogate Act in 1991.

Burzynski believes health care reform is a national concern, and he hails U.S. Rep. J. Dennis Hastert's (R-Yorkville) health care reform plan, which is incorporated in the Republican "Action Now Health Care Reform Act of 1992." "It's really a plan that's very viable and offers some options to what we currently are seeing. It helps small companies; it corrects the tax code for small businesses and those who are self-employed; and it also encourages people to save for their medical costs and not spend money unnecessarily for their health care."

He supports caps on noneconomic damages but has not decided on a dollar amount. "I know there are several numbers being floated, [but] I really don't know what that figure might be."

He said the current Medicaid program is unfair to patients and providers alike, but he does not have a "firm suggestion as to how we tackle the Medicaid situation right now."



**John M. Nelson – Democrat**

John M. Nelson is a Rockford lawyer seeking to represent the 35th Legislative District.

Also a believer that health care reform is a national problem, Nelson is a Democrat who does not favor the universal health care reform plan considered in the last session. "I had a primary opponent who advocated the universal health care bill pending in the legislature, and I beat him over the head with it.

I calculated that the cost of something like that could be as high as \$54 billion, which would triple the state budget and is cost-prohibitive."

He hopes the Congress will enact a health care reform plan that is "sensible, but if [if doesn't], then I am in favor of a supplemental plan."

As an attorney, Nelson said he does not support caps on noneconomic damages, because the economics of trying such cases make high judgments necessary. He would, he said, be open to other solutions, such as establishing an alternative dispute mechanism.

37  
th  
DISTRICT



**Todd Sieben – Republican**

Rep. Todd Sieben of the 73rd House District would also like to move up to the Senate. A businessman from Geneseo, Sieben has been a House member since 1985.

Sieben said tort reform is a crucial component of health care reform. "It seems to me that doctors and hospitals practice defensive medicine and order extra tests to protect themselves from potential lawsuits. We are in a litigious society today, and people seem to want to sue for everything possible they can get a claim on. And so obviously, for the doctor or the hospital, this raises their costs significantly." Sieben said he favors caps on noneconomic damages.

Sieben said improving the state's Medicaid problem depends on the state's economic recovery, "so I think that's a long-term problem. Because of the state's fiscal condition, it's going to take us quite a while to work it out."

Sieben also favors additional private insurance coverage options based on health maintenance choices, and he said that people should be more involved in purchasing their insurance so they would have a better idea of health care costs.

**Eric Gubelman – Democrat**

Eric Gubelman of Freeport, a former newspaper editor, has been assistant to the mayor of Freeport for the last three years.

Gubelman opposes a statewide single-payer health care program and supports several initiatives for health care reform. "I favor requiring health insurance companies to cover pre-existing conditions; establishing some reinsurance pools to cover private insureds with high costs; requiring the insurance industry to use community rating standards; standardizing claim forms; standardizing methods of review for managed care; requiring insurance to cover preventive medical services; and reducing state-mandated benefits."

He said he would look carefully at the Oregon plan to get a handle on Medicaid. "What Oregon is doing is worth taking a very close look at. The critics say it's rationing, but we already have rationing; it's just [done] in the most irrational way."

He said he has an open mind on caps on noneconomic damages. "Comparing the state of Illinois to Indiana, the information I have is that it's not resulted in lower health costs to the consumer, and that's the bottom line. Until someone shows me that tort reform translates into that, I'm going to be very wary."

34  
th  
DISTRICT



## 39th DISTRICT

**Dan Cronin – Republican**

Rep. Dan Cronin is a first-term member of the House running for the Senate in the newly drawn 39th District. An attorney residing in Elmhurst, he had represented the old 40th House District.

Cronin said there is no one simple, short-term solution to the health care crisis. "I think the responsible approach is a multifaceted approach. I think the first goal of any reform of our health care system is to preserve that which is good in our system. And we need to recognize that we have the most sophisticated health care delivery system in the world."

Opposed to a single-payer, government-run system, Cronin said, "I firmly believe that which works well is based on the free market. I think allowing doctors to pursue their practice unfettered by a lot of government oversight and regulation is the best component of our health care system. That must be preserved."

Cronin cited managed care emphasizing primary care and prevention, employer incentives, joint risk pools, private health insurance reform and malpractice reform as significant components of any prospective reforms.

He is willing to consider caps on noneconomic damages. "I think caps are a fair way to stop spiraling litigation costs."

**Ted E. Leverenz (I) – Democrat**

Sen. Ted E. Leverenz of Maywood served in the House from 1975 to 1991. He was appointed to the Senate in 1991 to represent the 26th District, and he is running for election in the new 39th District.

Leverenz said the current health care system needs to be "overhauled" but that "it should be done on a federal, instead of a state, level." He thinks, however, that the federal government will wait to see how the states try to solve the problem. After that, he said, "I suspect [the federal government] will probably come in and say, 'This is how we're going to do it.'"

Leverenz supports a single-payer system "so that all of the forms are standardized. We might be able to make an economy of some \$85 billion just by sending everything through the same system." But he cautioned that a single-payer system does not necessarily mean a government-run system. "It will be a mix between the public and private sector."

Regarding caps on noneconomic damages, Leverenz said, "That has to be weighed against the individual's right to fair and just treatment." He observed that enormous judgments are rare, "but weigh that against all of the claims in total. It's almost easier to have everybody sign a waiver saying, 'I trust my doctor; therefore he doesn't have to practice defensive medicine.' Somewhere in the middle lies the truth."

## 43rd DISTRICT

**Charles "Chuck" Pangle – Republican**

Republican Charles "Chuck" Pangle formerly served in the Illinois House of Representatives for three terms and as Kankakee County treasurer for two terms. A real estate broker from Kankakee, he said he has a consulting firm, which he will divest himself of should he be elected.

"If in fact there is going to be any attempt to have universal health care, it would have to come from the federal government," said Pangle. "And I don't think the federal government, with the deficit, is in any way, shape or form able to have such a program."

Pangle said this nation's problems are more difficult than those in other countries, such as Canada, that have universal programs. "For us to take that kind of a burden on is, I think, a ridiculous idea."

In the malpractice arena, Pangle favors a \$250,000 cap on noneconomic damages. "The doctor has to protect himself so much that it drives up health costs."

**Thomas A. Dunn (I) – Democrat**

Sen. Thomas A. Dunn is the 42nd Legislative District incumbent running for re-election in the newly drawn 43rd District. A Joliet attorney, he has served in the Illinois Senate since 1983.

"I know the No. 1 item with doctors is to ensure that patients will have the right to choose their own doctor, and I agree with them," said Dunn. "I think that [reform of] health care is a coming event in our society, and it's going to be done on the federal level, so that we don't have patchwork programs in different states."

Dunn praised physician efforts in Will County, "where the doctors give their time to the poor and have, in fact, referred patients to specialists who also agreed to take on those patients without [payment]. I wish that more doctors in the other counties would do the same."

Dunn said he is "yet to be convinced" that caps on noneconomic damages are "going to lower the rate on [malpractice] premiums." Dunn said

## 50th DISTRICT

**Karen Hasara – Republican**

Rep. Karen Hasara, who has represented the 100th House District since 1986, wants to be voted across the lobby to the Senate chamber. She was chief sponsor of the AIDS Notification bill in 1991 and voted against the Health Care Surrogate Act.

"If I had the easy solution [to the state's health care crisis], I would have given it a long time ago," said Hasara. "And I think that the fact that no one has

the easy solution shows how difficult the problem really is.

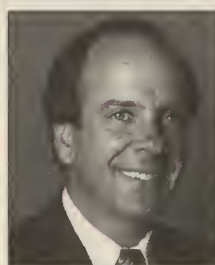
"I do feel strongly that we have the best health care in the world for those who are insured, even for those on Medicaid," she continued. "And so when we talk about making it more equal for everyone, it appears to me that we're going to lower the standard for some so that others have any standard at all. And I don't think Americans are going to stand for that."

Hasara said that people need to be more involved in purchasing their insurance, so that they have a better idea of health care costs. She also said the ultimate solution should occur on a national level. Hasara said she supports a cap on noneconomic damages but has not decided on a dollar amount.

**Douglas Kane – Democrat**

Mr. Kane did not return telephone calls requesting an interview.

## 55th DISTRICT

**Frank C. Watson (I) – Republican**

Sen. Frank C. Watson, a pharmacist from Greenville, served in the House of Representatives from 1979 to 1983, when he went to the Senate.

Watson attributes much of the rise in health care costs to increased malpractice premiums. "As a result, something that needs to be done is tort reform, maybe putting a ceiling on awards and giving some relief to the medical community."

As a pharmacist, Watson said he knows "firsthand the problems of the Medicaid payment cycle." Watson vowed that the "first priority of my next term of office is to make sure that those bills are paid in a timely fashion and to create the revenue necessary to do it."

Watson opposes single-payer, universal health care. "I've heard proponents of universal health care talk about government being able to do it in a more cost-efficient manner. I've been here 14 years and know firsthand that government does not do it cheaper."

**Craig Virgin – Democrat**

Mr. Virgin did not respond to repeated requests for an interview.

## 58th DISTRICT

**Ralph Dunn (I) – Republican**

Incumbent Sen. Ralph Dunn, 78, has been a member of the General Assembly for 19 years. He served 12 years in the House of Representatives until 1985, when he went to the Senate.

"I think one of the problems is tort reform, and I have supported tort reform all the way along," said Dunn.

He said he did not support a specific health care reform proposal "But I know if we do [institute universal health care], it should not be an Illinois thing; it needs to be a federal thing. We cannot afford universal health care in Illinois. We heard last year about the Canadian plan and how great it was, but I know the cost was prohibitive and something I would never consider voting for."

He said the state has to address the Medicaid problem. "I'm not in agreement with the governor on the fact that he's borrowing money and paying [providers] and then borrowing again. That's not going to solve our problem." Dunn believes the solution is some kind of one-time infusion of revenue to "get the government out of debt to the health care providers."

**Kenneth V. Buzbee – Democrat**

Mr. Buzbee did not return telephone calls requesting an interview. ■



# Physicians at Cook County react to abortion controversy

*In the middle of the court fight over reinstating elective abortions at Cook County Hospital, physicians, patients and staff deal with the issue on a personal level. By Stacie Crozier*

It's mid-September, and doctors and staff at Cook County Hospital wait.

Some wait apprehensively. A Cook County Circuit Court decision upholding the authority of Board President Richard J. Phelan to reinstate elective abortions to the facility is being appealed. It could, however, spark the threatened protests by pro-life supporters at the homes of doctors, nurses and support personnel who would staff the program. At the time this issue went to press, Phelan had said elective abortions would resume as of Sept. 17, but that remains to be seen.

Others wait impatiently, hoping that resumption of the program will provide an easier, more effective way to restore reproductive choice, family planning education and patient follow-up to Chicago's poorest women.

Although the court battle has focused on Phelan's executive power vs. the board's authority, the more volatile issue of abortion itself – argued between pro-

physician added.

"A significant number of our patients do seek abortions and have to go elsewhere. We have no way of following up on these patients, and we have no way to determine if they've received prompt follow-up care or any information on how to prevent the need of other abortions in the future."

Although many of the hospital's 6,000 employees – from physicians to clerks – support the program, many are apprehensive of the consequences of volunteering to staff the program, and the overall mood is "tense," the physician said.

"A lot of staff, especially the ward clerks, are scared. Pro-lifers have come to the hospital and told staff they would come to the new clinic when it opens, identify employees and come to their homes and picket," said the physician. "It's a very emotional issue. The people it hurts most significantly right now are our patients and support staff who basically just handle paperwork."

Another physician, who served on the hospital's task force to develop and implement the program, said that most staff members support the program, and the hospital has more than enough volunteers to run it.

"Our staff volunteers know who our patients are. They understand that these patients will be coming here because they have nowhere else to go," the task force physician said. "These are women who have few other choices. Just because they don't have the resources to go elsewhere ... that doesn't mean they shouldn't be able to obtain legal reproductive health care services. Volunteers consider this program an important part of providing better health care services for medically indigent women."

The task force of about two dozen physicians, nurses, laboratory technicians and administrative, financial and clerical staff designed a program that was totally voluntary and scheduled around other clinics, the task force physician said.

"We were an operational task force, not just a 'think tank.' We worked as a good, solid team, from arguing multiple points of view very thoroughly to implementing a working plan for the program that doesn't cut any other services in the hospital."

Another hospital division chairman said the court-centered delay in reinstating abortions has been damaging to patients who had already undergone pre-procedure counseling when a restraining order blocked resumption of abortions.

"There were women in the waiting area who'd already been scheduled for the procedure [who] had to be turned away," the physician said. "I saw their looks of dejection. One or two of them were crying."

Those few women, the physician said, were helped by a local social service agency. But the clock is ticking for many other indigent women who seek abortion services.

"The staff volunteers were also disappointed," the physician added. "They



**Elective abortions were scheduled to be resumed at Cook County Hospital Sept. 17. A Cook County Circuit Court decision upholding the authority of Board President Richard J. Phelan to reinstate elective abortions to the facility is being appealed.**

felt for the patients who had already been scheduled, because the restraining order was such a last-minute development. Volunteers feel that abortion is a

legal procedure that poor women should have the same right to obtain as rich women, and they feel our hospital should be able to provide this service." ■

**T**hese are women who have few other choices. Just because they don't have the resources to go elsewhere ... that doesn't mean they shouldn't be able to obtain legal reproductive health care services.

life and pro-choice supporters – is the one that hospital staff must deal with on a personal level.

Many physicians contacted for this article declined to speak, and no nurses or support staff would consent to be interviewed. Those physicians who were interviewed preferred to remain anonymous.

**NOT ALL PHYSICIANS CAN** personally support the proposed elective abortion program, said a division chairman on the hospital's staff, though most would support its presence at Cook County.

"Some of the staff have very strong pro-life beliefs," said the physician. "They say they fear women will use abortion as a method of birth control. But the program developed by the hospital task force has built-in controls that should prevent this from happening."

Those controls include limits on the number of procedures a woman can obtain, thorough follow-up for all patients who undergo the procedure and extensive family planning education, the

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# Hawaii and Minnesota: A tale of two states

**REFORM:** After 18 years, Hawaii's universal coverage program looks fresh to many who want states to make their own move. But Minnesota takes a different tack. By Scott Epstein

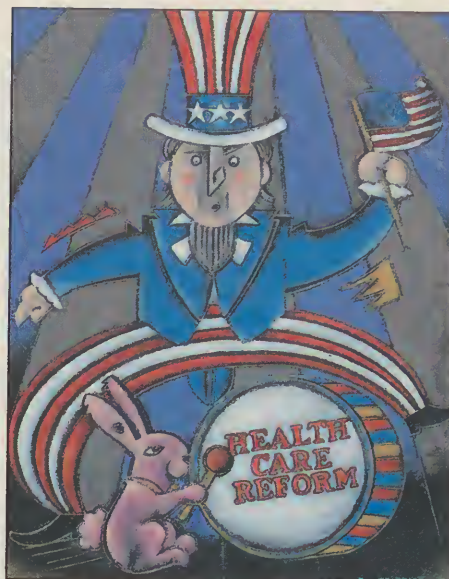
[ CHICAGO ] With the campaign gridlock in Washington delaying federal health care reform legislation, some states are taking matters into their own hands. Hawaii and Minnesota are two that have weighed in with their own homegrown health care reform.

Back in 1974, when health care costs were a "mere" 8.3 percent of the gross national product (vs. an estimated 13 percent in 1991) and "only" 12.2 million people were without insurance (vs. an estimated 37 million-plus in 1991), the state of Hawaii developed an unprecedented universal health care system that, in 1992, some consider a viable model for the nation.

Hawaii's Prepaid Health Care Act of 1974 established minimum standards of health care coverage for most of the workers in the state. The act required all employers (defined as an entity having at least one employee who works a minimum of 20 hours per week) to provide health insurance coverage. Under the Act's provisions, employees pay up to 1.5 percent of monthly wages or one-half of the premium costs, whichever is less, and employers pay the rest. Small businesses financially burdened by the mandate can draw from the state's "premium supplementation fund."

Employers are not required to offer dependent coverage, although to compete for the best workers in a low-unemployment state, 90 percent do.

Employers must offer the same minimum coverage, which includes 120 hospital days, intensive medical care while



B.A. FRIEDMAN

hospitalized, hospital outpatient care, physician services (home, hospital and office), diagnostic and laboratory services, maternity care, and *in vitro* fertilization benefits.

By 1989, according to the state department of health, more than 88 percent of Hawaii residents were insured by the program and Medicare, while 7 percent were covered under Medicaid.

To cover the 5 percent who fell through the cracks – residents who are unemployed, work less than 20 hours per week, or do not qualify for Medicaid – Hawaii established the State Health Insurance Plan. SHIP benefits emphasize primary and preventive care rather than inpatient hospital services. Patients are entitled to 12 physician visits each year

and five days of hospitalization, with a \$2,500 expense limit. Eligibility requires Hawaii residency and a gross income between 65.5 percent and 300 percent of the federal poverty level. State residents covered under SHIP must make a \$5 co-payment for medical services and pay a monthly premium based on income. The state subsidizes the rest. To date, 98.5 percent of Hawaii's resident population has health care coverage.

In an exclusive interview with *Illinois Medicine*, Hawaii Medical Association President Stephen Wallach, M.D., said, "It's nice that almost everyone has insurance and can come to the office and get treated. There's not a barrier." Nevertheless, he said, "Physicians all over are experiencing the same financial squeeze." He noted that in Hawaii, Medicaid reimburses 50 cents on the dollar, and "SHIP may not pay enough."

**WHILE ASPIRING TO** Hawaii's goal of universal health care coverage, the state of Minnesota uses a different approach to cover its uninsured. Minnesota takes the financial responsibility off the employer and puts it squarely on providers, private insurers and cigarette smokers. And because the state didn't ask for Medicaid waivers – as Oregon did – Minnesota did it without the need for federal approval.

The state introduced a solution called "MinnesotaCare" (formerly known as "HealthRight") in April 1992, after four years of study. The voluntary program will be available to families with children

in January 1993 and to all state residents in January 1994.

MinnesotaCare provides state-subsidized insurance coverage – focusing largely on primary and preventive care. Residents are eligible to enroll in this voluntary program if they do not qualify for Medicaid, have incomes of less than 275 percent of the federal poverty level, have been uninsured for four months and have been without employer-provided insurance for 18 months.

Those who enroll must pay premiums ranging from an estimated 1.6 percent of household income for the poorest people, to 8.1 percent of household income for those relatively better off.

*Minnesota expects only 158,000 of the estimated 400,000 uninsured to join by 1997.*

Because participants must pay a premium, the state expects only 158,000 of the estimated 400,000 uninsured to join by 1997. Annual cost estimates for the program range from \$200 million to \$570 million, but the ultimate cost is unknown, due to the voluntary enrollment element.

MinnesotaCare is being financed by a 5-cents-a-pack increase in the state's cigarette tax, a 2-percent tax on the gross revenue of health-care providers, including physicians, and a 1-percent tax on health insurers. (See story below.) ■

## Minnesota doctors react to tax on providers

**PROVIDER TAX:** Doctors, hospitals and insurers react to state program funding. By Scott Epstein

[ CHICAGO ] A lawsuit filed Sept. 2 alleges that Minnesota's state health care plan, MinnesotaCare, violates the federal Employee Retirement Income Security Act and federal labor laws.

ERISA requires self-insured plans to use assets to benefit only their participants, according to William Cumming, an attorney for the Pipe Trades Trust. Cumming said the trust objects to the funding for MinnesotaCare, not its basic programs. "A better funding mechanism would be a general tax assessment."

That opinion was also held by the Minnesota Hospital Association and the Minnesota Medical Association. When the state proposed to fund the program by imposing a 2-percent tax on physicians and hospitals, and a 1-percent tax on not-for-profit insurers and HMOs, the MHA and the MMA predicted the

plan would force hospitals to close and physicians to leave the state.

Thomas Stolee, M.D., MMA president, said that although most Minnesota doctors agreed that the state had to increase access and reduce costs, many physicians couldn't get past the tax issue. "One doctor quit the association," he said. "Basically, we feel that this tax is regressive and could have a negative impact on the state's economy. The taxes we proposed would have made more sense."

Not-for-profit insurers and HMOs, with their 1-percent tax on gross premiums (which begins in 1996), aren't exactly off the hook themselves. Yet their financial liability is considerably reduced, thanks to Blue Cross and Blue Shield of Minnesota's successful efforts to cut the tax for insurers from 2 percent to 1 percent. The bill also enables insurers to pass the tax through

to subscribers. Blue Cross is, however, still "pursuing other means of funding the program," according to Blue Cross spokesman Earl Johnston.

The MHA presented its own version of a plan to control health care costs and to increase access. To finance the package, the MHA called for a broad-based tax, such as a health care surcharge on income taxes or a half-percent addition to the state's current 6-percent sales tax. The MMA supported a combination payroll, income, tobacco and liquor tax plan. But Minnesota Gov. Arne Carlson vowed to veto any bill that included an income tax, and the provider tax stayed.

The MHA says it will "try [its] best to make sure it works," said Patti Anderson, MHA's vice president of public affairs, adding, "It's the law."

"During the debates, the good parts of the bill didn't get attention," continued Anderson. "For example, [the bill] will increase access. Antitrust provisions [and special payments] will help struggling rural hospitals. And the insurance reform aspects of the bill will encourage consistent utilization review to reduce unnecessary administrative expenses."

The MMA was concerned that MinnesotaCare was too expensive for the

uninsured. And with inpatient care limited to a \$10,000 family maximum per year, it offered too little for the money, the state's doctors claimed. The medical association has assembled a task force to "dissect the 200-page bill and work with the legislators" to make any possible modifications, according to MMA's Director of Communications Mark Vukelich.

Stolee said the media, eager for a good story, claimed a strained relationship existed between the state and the MMA. In fact, "we ultimately supported 85 to 90 percent of the bill," Stolee said. The MMA ended up opposing the legislation because of a few factors, albeit important ones. These include the provider tax, which physicians cannot pass through to insurers or patients. And, even more important, according to Stolee, the bill mandates that all doctors accept Medicare patients.

Effective Oct. 1, payments under the Medicaid program and other state programs will increase by an average of 25 percent for physicians, dentists and other providers, and by 25 percent for hospital outpatient services. The down side is that the increase will be funded by a \$400 yearly licensing fee increase for physicians, to be matched by the federal government. ■

*"Basically, we feel that this tax is regressive and could have a negative impact on the state's economy. The taxes we proposed would have made more sense"*

THOMAS STOLEE, M.D.



## MEMBERS IN THE NEWS

**Silvana Y. Menendez, M.D.**, of Belleville, was recently appointed vice chairman of the American Medical Association's new Advisory Committee on Minority Physicians. A former medical director at St. Louis State Hospital, Dr. Menendez, a psychiatrist, has been in private practice since 1971.

Dr. Menendez has served as president of the St. Clair County Medical Society, and chairman of both the Illinois Council on Mental Health and Drug Addiction and the ISMS Hospital Medical Staff Section. She is currently an alternate delegate to the AMA, a member of the ISMS Physician Assistance Committee and a member of the American Psychiatric Association.

**Denise M. Mammolito, M.D.**, of Dunlap, was recently inducted into the Society for Surgical Oncology. The society, founded in 1940 at Memorial Hospital of Cancer Diseases in New York City, has an international membership of only 900 physicians.

Dr. Mammolito trained at the Uni-

versity of Medicine and Dentistry in New Jersey and began practicing in Peoria in July 1991. She is an associate fellow of the American College of Surgeons, and a member of the Association of Women Surgeons and the American Society for Gastrointestinal Endoscopy.

**Joan E. Cummings, M.D.**, director of Edward Hines Jr. VA Hospital, Hines, now serves as editor of *The Times*, the hospital's new monthly newspaper, which debuted in August.

Associated with the hospital since 1971, Dr. Cummings has been director since 1990. She is also an ISMS Third District trustee, former speaker of the ISMS House of Delegates and chairman of the Committee on *Illinois Medicine*.

**Carolyn C. Lopez, M.D.**, of Chicago, has been elected president of the Illinois Academy of Family Physicians. Dr. Lopez, the first woman and the first person of Hispanic origin to be president of the IAFP, was also named alter-

nate delegate to the American Academy of Family Physicians.

Former chairman of the board and speaker of the IAFP Congress of Delegates, Dr. Lopez is assistant dean at Rush Medical College and is medical director and vice president of Access HMO, a part of Rush Health Plans. She is a fellow of the American Academy of Family Physicians and a diplomate of the American Board of Family Practice.

**Danca Luchici, M.D.**, of Lacon, has joined the medical staff at Kewanee Hospital and opened her practice at Kewanee Internal Medicine in July.

Following medical school, Dr. Luchici spent four years in research in nephrology and immunochemistry at Cook County Hospital in Chicago and at Evanston Hospital. Prior to joining the Kewanee Hospital staff, she had an internal medicine practice in Pekin.

**Jan A. Fawcett, M.D.**, of Chicago, the Stanley G. Harris Sr. Professor of Psychiatry and chairman of the department of psychiatry at Rush-Presbyterian-St. Luke's Medical Center, has been named the first Grainger Director of the Rush Institute for Mental Well-

Being. The directorship was established earlier this year through the philanthropy of David and Juli Grainger.

**Elizabeth B. Korte, M.D.**, of Carthage, received the Simpson College Humanitarian Service Award during Alumni Weekend in June. A family physician, Dr. Korte also serves as director of the medical staff for a nursing home, delivers about 60 babies each year and covers the hospital emergency room once a week.

In 1990 Dr. Korte was named Family Physician of the Year by the Illinois Academy of Family Physicians, and 1990 Family Doctor of the Year by the American Academy of Family Physicians.

**Helen Gitlevich, M.D.**, of Wheeling, has joined the medical staff of Alexian Brothers Medical Center in Elk Grove Village. A family physician, Dr. Gitlevich stresses patient education and preventive medicine in her practice.

Dr. Gitlevich is a member of both the American Academy of Family Physicians and the Illinois Academy of Family Physicians.

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**Retired outpatient GP**, 56, LaSalle County native, seeks outpatient work within commuting from Streator/Ottawa. John Rees, M.D., RRI, Grand Ridge, IL 61325; (815) 249-5584.

**Family practice opportunity** in southern Illinois. Join young progressive two-FP practice looking to expand. Immediate partnership possible. High-demand area, excellent income. OB optional and available if desired. Excellent location near hospital. Please send replies to Box 2223, % *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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**Physiatrists, neurologists,** rheumatologists, internists/cardiologists. Social Security Administration's Disability Programs Branch in downtown Chicago is looking for contractors for part-time work, Monday-Friday, 7 a.m. to 5:30 p.m. Job entails review of medical evidence in disability claims. No contact with patients. Unrestricted license in any state required. Submit letter of interest to: HHS, Region V Contracting Officer, 105 W. Adams, 22nd Floor, Chicago, IL 60603. for RFP 93.2.

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**Serving Illinois** for over 10 years providing radiology and primary care locum tenens and permanent placement services. Malpractice insurance provided. Numerous references available. Contact Jerry Ortiz, President, Physician Placement Specialists, P.O. Box 791, Brookfield, WI 53008-0791; (800) 747-0606.

**Certified gynecologist/FP** seeks association/locum tenens. Available for office practice. Please send inquiries to Box 2212, % *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

**Radiologist, semi-retired,** wants part-time position, Chicago metropolitan area, reading plain films and doing GI and GU studies. Experienced. Please send replies to Box 2220, % *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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## HCFA

(Continued from page 1)

109 submissions. Once HCFA receives the registration fee, it will issue a CLIA number. After Dec. 1, Medicare and Medicaid will check physician identification numbers on their claims with the CLIA number to verify registration before reimbursing the physician.

Illinois physicians who have submitted their CLIA registration payment but have not received their number by the first week in November should contact the Health Standards and Quality

Bureau in HCFA's Chicago office at (312) 353-9805.

**IN A RELATED DEVELOPMENT**, the American Medical Association Aug. 28 announced success in its effort to get HCFA to provide notification of its intent to inspect a physician's office lab unless a problem is suspected or a complaint has been filed.

The AMA, concerned that unannounced inspections would disrupt patient care, had lobbied HCFA to use announced inspections to help physicians comply with the law instead of penalizing them for noncompliance.

In a letter to James S. Todd, M.D.,

AMA executive vice president, U.S. Health and Human Services Secretary Louis W. Sullivan, M.D., said he recognized the AMA's concern and added, "We will take great care to sensitize our surveyors during their training about respect for patient privacy, the importance of not interrupting patient care and the extraordinary demands on a physician's time."

**FINALLY, PHYSICIANS WHO HAVE** questions about their obligations under CLIA-88 have a variety of resources at their disposal. The AMA has published the booklet "What Every Physician Should

Know About CLIA," available at no charge to AMA members. To obtain a copy, call the AMA Member Service Center at (800) 262-3211. In addition, ISMS members will receive an ISMS-produced brochure on complying with CLIA with their Oct. 9 issue of *Illinois Medicine*.

And Illinois physicians who have not yet filed their HCFA Form 109 may obtain one from the Illinois State Medical Society Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. ■

## ISMS message

(Continued from page 1)

spectrum, from legislative issues to malpractice questions. Members receive quick responses to their questions, and their concerns are aired before councils, committees and the board.

Beyond serving members, the ISMS president acts as the primary public spokesman for the Society. When the media call, often on a fast deadline, the ISMS president must be available to respond and must have up-to-date information to represent the members' position. While visiting Illinois county medical societies, the president visits with local media, to bring the ISMS message to all areas of the state. In addition to giving newspaper, radio and television interviews, the president also may be asked to address other, nonmedical groups, carrying the Society's message to nonphysicians. Groups such as Rotary, Kiwanis and Chamber of Commerce offer the president a broad venue outside medicine.

**THE PRESIDENT DOES MORE** than respond to requests from the public and media. The president also works proactively with the media and the public, speaking out when ISMS has an accomplishment the public should know about. The president is the ISMS "educator" and tries to keep both the media and the public informed about the medical profession's views on issues. When the president is not available, the president-elect steps in to help with media and other appearances. Both the president and the president-elect attend border-state medical society meetings to represent Illinois to our Midwest colleagues.

ISMS members who want to keep up to date on what's happening in Illinois health care and what ISMS is doing for them, should read *Illinois Medicine* regularly. If members have something to communicate, we actively encourage letters to the editor.

Beyond having *Illinois Medicine*, ISMS members have their own personal messengers. They are Arvind K. Goyal, M.D., current ISMS president, and all the presidents who have preceded and who will follow him. ■

*Editor's Note: Dr. Goyal is also available the first Wednesday of every month at ISMS headquarters to take phone calls from members.*

# Have You Read The Headlines?

There is a way to treat obesity  
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### The 42nd Annual Obesity & Associated Conditions Symposium of the American Society of Bariatric Physicians

(15 ACCME Category I credit hours available. This program has been reviewed and is acceptable for 13.50 prescribed hours by the American Academy of Family Physicians.)

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(10 ACCME Category I credit hours available.)

This program has been reviewed and is acceptable for 10 prescribed hours by the American Academy of Family Physicians.)

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**Westin Hotel, Chicago, Illinois**



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- ☐ Associate membership in the American Society of Bariatric Physicians (open to advanced-degreed dietitians, psychologists and exercise physiologists.)

- ☐ Subscription information for the *American Journal of Bariatric Medicine*, *The Bariatrician*.

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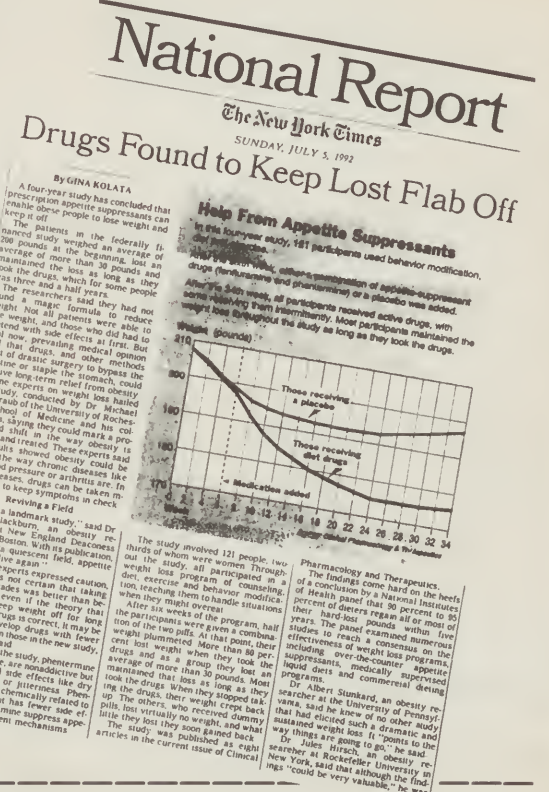
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**American Society of Bariatric Physicians**

5600 S. Quebec St., Ste. 160-D

Englewood, CO 80111

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## ISMS Board Briefs

(Continued from page 15)

to practice in rural Illinois.

In a related action, the board approved allocations to Illinois medical schools from physician family contributions to the Educational and Scientific Foundation in the amount of \$270,000. These funds are earmarked for medical student loans to be administered through the eight Illinois medical schools. The board also recommended that members of the ISMS, ISMIE and ISMIS boards would each contribute \$50 for the ISMS Auxiliary holiday sharing card, with the proceeds going to the AMA's Education and Research Foundation.

### IDPA to offer electronic billing

Physicians will have the option of submitting bills electronically to IDPA. ISMS has worked closely with IDPA to ensure that electronic billing be voluntary, not mandatory, and that appropriate safeguards for physicians and their patients be in place.

### ISMS works to improve IDPH/IDPA vaccine program

In April 1992, federal mandates required physicians who administer vaccinations to provide educational materials to patients before the vaccination. ISMS has worked closely with IDPA and the Illinois Department of Public Health in implementing this federal program, to protect physicians and their patients. IDPA has added hepatitis B vaccine to the program, even though it is not a mandatory immunization.

### Medical-legal information document available

In response to member requests for information about legal concerns in medical practice, ISMS prepared a document that answers physicians' most common questions. Developed by the Medical Legal Council, the document is intended for limited distribution because of the projected need for routine updating of material included. However, the ISMS board asked the council to consider a broader distribution of the information contained in the document, because of the high level of interest in – and need for – this information.

### ISMS to distribute CLIA compliance brochure

Members who need essential information on how to comply with the federal Clinical Laboratory Improvement Amendments will get what they need in a new ISMS brochure. The brochure is designed to provide Illinois physicians who operate office laboratories with practical ways to comply. Current plans are to distribute the brochure with the Oct. 9 issue of *Illinois Medicine*.

### Rural health care brochure addresses access issues

ISMS has developed and produced "Rural Health: Reaping the Benefits of Community Action," aimed at helping medical societies and communities identify and deal with rural health access problems. The brochure provides information on producing solutions through effective organizing and rural health resources. ISMS is seeking interested physicians who will be advocates for this

rural health initiative by participating in speaker training and speaking before community and medical society audiences about how to address rural health care problems. The brochure will be provided to all county medical societies in the near future. Other requests for the brochures can be directed to the ISMS Division of Health Care Finance.

### ISMS opposes DASA fee increase

The Illinois Department of Alcoholism and Substance Abuse has proposed revising rules governing fees for 100 triPLICATE-prescription pads. DASA has proposed an increase from \$10 to "a reasonable fee," which has not been deter-

mined. The current fee and inconvenience caused by the program's requirements have already limited participation in the program, which is aimed at deterring the diversion of controlled substances. ISMS opposes the fee increase.

### ISMS residency interview seminar

"Preparing for Residency Interviews" is the popular ISMS-sponsored program that helps medical students prepare for the residency match process. This year's Sept. 26 program at the Fairmont Hotel in Chicago includes information about the National Resident Match Program and skill-building interview sessions for medical students. ■



## Physician HELpline

A 24-hour physician HELpline is available to link impaired physicians and their families with helpful resources. Contact the ISMS Physician HELpline at (312) 580-2499.



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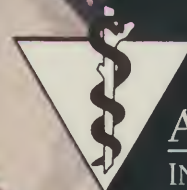
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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

**References:** 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Breaking the  
chain of family  
violence

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# Illinois Medicine

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code specifies  
DNR  
requirements

PAGE 21



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**THIRD-YEAR SOUTHERN**  
Illinois University School  
of Medicine student Tina  
Schrader (above right),  
talks with Ginny Heubach  
(above left), and Dennis  
Mahoney of Morris Hospi-  
tal in Morris at SIU's annu-  
al Doctors Fair Sept. 18.

## Physician assistance programs extend a helping hand to impaired doctors

**PHYSICIAN ASSISTANCE:** An ISMS program and a regional committee in Peoria provide services to help impaired doctors. By Stacie Crozier

[ CHICAGO ] When Illinois doctors with an impairment need assistance, they can expect a helping hand – not a disciplinary slap. Physician assistance is a positive way to address a problem traditionally perceived as negative, even taboo.

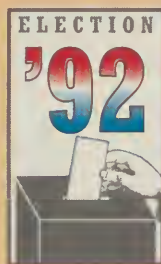
Funded by a grant from the Illinois State Medical Inter-

Insurance Exchange, the Illinois State Medical Society contracts with an outside case management firm, Parkside Medical Services in Park Ridge, to provide services to the program. The ISMS Physician Assistance Program and its Physician Assistance Committee help

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## Edgar restricts self-referral and exempts physicians as execution witnesses

**BILLS:** Gov. Edgar signs two measures closely watched by Illinois physicians. By Tamara Strom

[ SPRINGFIELD ] Under a bill signed by Gov. Jim Edgar Sept. 25, health care workers, including physicians, will face new restrictions in referring patients under certain circumstances. Specifically, health care workers are prohibited from referring a patient to an entity outside their office practice or the group practice in which they invest, unless they directly provide health services within the entity and will be personally involved with pro-



Gov. Jim Edgar

viding care to the patient. Under a second bill signed Sept. 25 by Edgar, physicians will no longer be required to act as witnesses in state-sponsored executions. Both measures had been closely watched by Illinois physicians.

The Health Care Worker Self-Referral Act limits many health care self-referral practices. For physicians, however, the most important aspect of

(Continued on page 25)

## Health groups weigh in with reform plans

**REFORM MANIA:** Groups representing nurses, hospitals and all kinds of physicians support a variety of plans for health care reform in the United States and in Illinois. By Ginny Thiersch

[ CHICAGO ] The American Medical Association, actively promoting its Health Access America program in Washington, has plenty of competition from other health care providers with health care reform plans. From Washington to Springfield, almost all the players in health care have – or support – a plan they think will best address the current health care crisis.

The American College of Physicians is the latest to come

up with a specific plan for reform; its proposal received much attention in the media by calling for a national cap on physician fees. Under the program a federal commission would set annual expense budgets for all health care services; the plan also includes a cap on noneconomic damages awarded in medical malpractice suits.

The proposal also calls for a modified “pay or play”

(Continued on page 13)

## ISMS BEHIND THE SCENES

## RESIDENT PHYSICIAN MEMBERSHIP IS THE SOCIETY'S FUTURE

Concerned about low levels of participation among resident physicians in organized medicine, the Illinois State Medical Society has developed a new member recruitment strategy to increase their ranks.

As of August, roughly 870 resident physicians – only 19 percent of those enrolled in Illinois residency programs – belonged to ISMS, a figure that has remained relatively stable over the past six years. That has many

leaders concerned about the Society's future.

“Residents are important not only because they are the future doctors for our people, but because they are the future leadership of the Illinois State Medical Society,” said Arvind K. Goyal, M.D., ISMS president. “The more we get them involved now, the more likely they are to remain involved later in their practice.”

(Continued on page 26)



## Second case of California encephalitis cited in Illinois

[ SPRINGFIELD ] The state's second confirmed case of California encephalitis, a mosquito-transmitted disease, was reported in Tazewell County, according to the Illinois Department of Public Health. The first case was confirmed in July in Sangamon County.

The patient, a 5-year-old resident of East Peoria, was hospitalized after laboratory tests confirmed the diagnosis of encephalitis.

IDPH is asking local health departments in and around Tazewell and Sangamon counties to watch closely for symptoms of this serious neurological disease.

Symptoms of encephalitis usually begin five to 15 days after the mosquito bite and range from a slight fever or headache to the rapid onset of severe headaches, high fever, muscle aches and disorientation.

The total number of confirmed encephalitis cases in Illinois has decreased since last year, when IDPH reported 15 cases throughout the state. ■

## Alzheimer's fund to remain on state tax form

[ SPRINGFIELD ] For the seventh consecutive year, Illinois taxpayers have contributed more than \$100,000 to the Alzheimer's Disease Research Fund, earning the state-administered fund the right to a slot on the 1992 IL-1040 tax form check-off list, the Illinois Department of Public Health reported Sept. 15.

"The fund has been on the list since 1985," said IDPH spokesman Karen Grueter, explaining that the \$101,617 donated by 15,077 taxpayers will support basic research into finding a cure for, delaying the progress of, and providing family assistance for, patients with Alzheimer's.

"Alzheimer's robs people of their dignity, memories and ability to care for themselves," said IDPH Director John R. Lumpkin, M.D. "It is a major contributor to disease and death in Illinois for people 60 years and older, but the most frightening and sad part of the disease is its cause is unknown and there is no known cure."

To remain on the check-off for the next year, contribution funds must have reached \$100,000 by Oct. 1, Grueter said. As of Sept. 9, three other funds had achieved that goal: the Illinois Non-Game Wildlife Conservation Fund, the Child Abuse Prevention Fund and the Assistance to the Homeless Fund. To date, 143,456 taxpayers have contributed \$930,142 to the 12 funds on the 1991 list.

Although primary Alzheimer's research funding is provided by the state, Grueter said the tax form contributions are divided among researchers who apply to the Alzheimer's Disease Assistance Act Advisory Committee. This year seven researchers were chosen from 25 applicants to receive grants. State funds are divided between Rush-Presbyterian-St. Luke's Medical Center in Chicago and Southern Illinois University School of Medicine in Springfield. Other hospitals also apply to participate in the state network for Alzheimer's research

but are self-funded, Grueter said.

Taxpayers may donate \$1 or more to any of the special tax funds by filling in the amount of their donation on state income tax forms. The indicated amount either decreases the refund or increases the tax balance due.

"Money contributed to this special fund will assist Illinois scientists who are working to find more effective ways to diagnose and treat Alzheimer's and, one hopes, discover a cure for this debilitating disease that afflicts more than 150,000 Illinoisans," Dr. Lumpkin said. ■

## DeKalb County announces domestic violence counseling program

[ DEKALB ] Taking its first step toward treating abusers, the DeKalb County Domestic Violence Task Force introduced on Sept. 15 its plans for a counseling program to address domestic violence.

"To this point we've had no adequate treatment program for abusers in DeKalb County," said Pam Wiseman, co-chairman of the task force and director of Safe Passage, which provides shelter for battered women in DeKalb County. She explained that although the counseling program has been in the works since 1990, Safe Passage has been helping victims of domestic violence for the past 12 years.

"Our goals are to end violence and to teach alternatives to coercive, dominating and violent behavior in intimate relationships," Wiseman said. The program, scheduled to begin in October, will treat groups of up to 10 men, who will meet once a week for 26 weeks, she explained. Participants will either volunteer or be referred to the program by a court. Before entering the program, abusers will receive psychological evaluations and be screened for substance abuse to "make sure drugs and alcohol won't impair the group," she said.

Counseling sessions will be led by



LOUISE NOAKES

**ISMS LEADERSHIP TRAVELED** to Washington, D.C., Sept. 22 and 23 to meet with a congressional delegation and other key policymakers on the issue of health care reform. Pictured above are (from left): ISMS President Arvind K. Goyal, M.D.; Harold L. Jensen, M.D., chairman of the Exchange Board of Governors; ISMS Executive Vice President Alexander R. Lerner; and U.S. Rep. Henry Hyde (R-Addison).

Wiseman and Charles Tucker, professor of interpersonal communications at Northern Illinois University in DeKalb. Also involved in the project are the state's attorney's office and the NIU Family Violence Research Center. Wiseman said 76 cases are pending that could be referred to the program by the state's attorney. "The number of participants will depend on how willing the courts are to refer cases," she said.

The task force based the program on a similar program in Duluth, Minn., she said, noting that several other Illinois counties have abuser treatment programs. The program will also encompass a research project that will gather statistics on domestic violence and evaluate the program's success. "Traditionally, less than 5 percent of abused women seek shelter," she said. "We see about 90 victims a month [at Safe Passage]. And it's a myth that abuse occurs only among lower socioeconomic groups."

The program will be funded through participant fees and the state, Wiseman said. She stressed that a fee helps abusers recognize the nature of their problem

and the need to take responsibility for their actions. "Our philosophy is, domestic violence is a crime and therefore a public, not a private, matter." ■

## Efforts continue to stop the spread of hepatitis

[ SPRINGFIELD ] Two separate immunization efforts are under way to help stop the spread of hepatitis in Illinois. The first comes by way of the Illinois Department of Public Aid, which now offers the hepatitis B vaccine through its Vaccine Replacement Program.

To meet growing demand, the department added the hepatitis B vaccine to other vaccines available to physicians treating public aid patients under the Vaccine Replacement Program. A federal grant will help defray the vaccine's cost. Although IDPH recommends physicians vaccinate everyone at high risk of the disease, inoculation is not mandated.

Health care providers are among those at high risk for hepatitis, because of their exposure to blood and blood products, but only 40 percent nationwide have been immunized, according to the U.S. Centers for Disease Control. Also at high risk are intravenous drug users, and people who have received blood transfusions, have undergone dialysis or have multiple sex partners.

(Continued on next page)

## PHYSICIAN FACTS

### National health care expenditures and percent of GNP, 1950-2000

Year	Nat'l. health expenses (in billions)	Expenditures per capita	Percent of GNP
1950	\$ 12.7	\$ 82	4.4
1955	17.7	105	4.4
1960	26.9	146	5.3
1965	41.9	205	5.9
1970	75.0	349	7.4
1975	132.7	591	8.6
1980	248.1	1,054	9.1
1985	422.6	1,710	10.6
1990	647.3	2,511	12.0
1995*	999.1	3,739	13.4
2000*	1,529.1	5,551	15.0

\*Estimates  
Source: Market Intelligence Research Corporation

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## Crescent Counties axes most on-site reviews, multiple physician appeals

**BUDGET CUTS:** Crescent Counties Foundation for Medical Care, the Illinois PRO, faces staff layoffs, elimination of multiple appeals and the end of most on-site reviews. By Ginny Thiersch

[ NAPERVILLE ] Facing significant budget cuts for the six-month interim period between Scopes of Work, the Illinois PRO eliminated multiple layers of appeals on physician quality review inquiries. Crescent Counties Foundation for Medical Care also will bring almost all nurse reviews and a substantial number of physician reviews in-house to the Naperville facility.

The changes were announced at the Sept. 21 meeting of the CCFMC Council for Governmental Review Programs. The PRO has negotiated a six-month contract with the U.S. Health Care Financing Administration designed to bridge the period between the end of the current Third Scope of Work and the Fourth Scope of Work scheduled to begin April 1, 1993.

While CCFMC declined to comment on the exact amount of the budget reductions, the changes implemented in PRO procedures, including staff cuts reaching a reported 17 percent, resulted in significant operational changes for the PRO.

Under the new budget, multiple physician appeals of PRO quality rulings were eliminated, the PRO announced. Effective Oct. 1, multiple committee review activities have been eliminated; their

functions will be performed by a quality intervention committee of three. As a result, CCFMC UR and quality findings in dispute under this "bridge" Scope of Work must be challenged effectively and in-depth the first time, Illinois State Medical Society experts say. No further safety net exists for physicians who fail to appeal vigorously on first notice.

A number of CCFMC committees will

be disbanded as a result of this budget reduction; committees reported to be maintained for the interim period will absorb some, but not all, of the functions of the committees that have disappeared. Among the committees the PRO will maintain are the Criteria Development Committee, the Quality Intervention Committee and the Sanctions and Determination Committee. A limited

future role is envisioned for the Consumer Advocacy Committee.

In addition, the PRO announced that most on-site nurse reviews would be eliminated; with the exception of some limited on-site review at rural hospitals, all nurse reviews and a substantial number of physician reviews will now be handled at the Crescent Counties Naperville facility.

As the Fourth Scope of Work focuses more on pattern analysis rather than physician review, the budget included funds for data processing and equipment to help the PRO with the changed focus.

CCFMC did not respond to repeated *Illinois Medicine* requests for comment. ■



# REPORT FOR *Illinois Physicians*

## BLUE SHIELD QUESTIONS AND ANSWERS

*Frequently asked questions of the Provider Assistance Unit*

### Where can I get membership verification, benefit, and claim status information ?

For the quickest response to your needs for routine membership verification, benefit, and claim status information on our members, please contact our Provider Assistance Unit at (312) 938-7340 and use your touch-tone telephone to enter the patient information requested.

Blue Cross and Blue Shield of Illinois representatives are also available to assist you Monday through Friday between 8:30 am and 4:15 pm.

### Where should claims be mailed ?

Blue Shield of Illinois  
PO Box 1364  
Chicago, IL 60690

### What is my patient's deductible ?

Please contact our Provider Assistance Unit at (312) 938-7340 and simply enter patient information as requested.

If special assistance is required for your request, a Blue Cross and Blue Shield of Illinois representative will assist you.

### When should reimbursement for my services be received ?

Generally, you should expect to receive reimbursement within 10 days of the date of your Provider Claims Summary (PCS) document. If you have not received reimbursement within this time frame, please contact the Provider Assistance Unit at (312) 938-7340 for further information.

## NEW GROUPS

Blue Cross and Blue Shield of Illinois is pleased to announce the following new employer groups effective third quarter 1992.

	Group Number
Baltimore Aircoil	900104, 900128
Powell Duffryn	NPD280

*(This report is published as a service to the physicians of Illinois.)*  
(10/9/92)

## Ortho targets consumers with birth control pill ads

[ RARITAN, NJ ] October issues of several national consumer magazines – including *Glamour*, *Mademoiselle*, *Self*, *Vogue*, *Health* and *People* – will feature the first birth control pill ads aimed at consumers. Ortho Pharmaceutical Corp. is running the ad, titled "We've Come Full Circle Since 1960," to reveal "no-nonsense" information about the risks and benefits of taking oral contraceptives. "We hope not only to dispel many of the myths that have surrounded pill use for the past 30 years ... but to encourage women to take a fresh look at oral contraceptives," said Ortho President Eric Milledge.

According to the 1992 Annual Ortho Birth Control Study, the pill remains the most popular birth control method in the United States, claiming 18.7 million users. In addition, oral contraceptives are the most widely researched pharmaceutical products in the world. Milledge said physicians will receive advance information about the ad campaign. ■



## Governor signs fibrocystic conditions bill

**BILLS:** Gov. Jim Edgar continues to narrow the list of health care-related bills awaiting his decision. By Kevin O'Brien

[ SPRINGFIELD ] Gov. Jim Edgar Sept. 13 signed an Illinois State Medical Society-supported bill mandating changes in the state's Insurance Code. The bill bans limitations and exclusions in health insurance policies for women with fibrocystic breast conditions.



applied to other insurance policies and health maintenance organizations, and urged that the law be extended to cover all insurers," Edgar said in a prepared statement. "Mammography has been credited with saving thousands of lives, and it would be a tragedy for women to forgo such cancer-detecting examina-

tions because they fear a fibrocystic diagnosis would result in the loss of their health insurance coverage."

A fibrocystic condition refers to a variety of natural changes in the breast that, for the vast majority of women, do not signal an increased risk of cancer.

H.B. 2825 also contains safeguards for the insurance companies, allowing them to exclude coverage if the insured's medical history confirms a chronic or relapsing breast condition, according to the governor's release.

Chief sponsors of the legislation were Reps. Lee A. Daniels (R-Elmhurst), Margaret Parcells (R-Northfield), David K. Deets, M.D. (R-Dixon), Jane M. Barnes (R-Palos Park), Virginia Fiester Frederick (R-Lake Forest), Barbara Flynn Currie (D-Chicago), Grace Mary Stern (D-Highland Park), Robert LeFlore Jr. (D-Chicago), Michael V. Rotello (D-Rockford), Janice D. Schakowsky (D-Evanston), and Ann Stepan (D-Chicago); and Sens. Jack Schaffer (R-Cary), Arthur L. Berman (D-Chicago), and Penny L. Severns (D-Decatur).

**In another insurance-related measure,** the governor signed a bill stipulating that health insurance policies that cover inpatient and outpatient alcoholism and drug dependency treatment cannot exclude coverage for any medically necessary services by "appropriately licensed providers."

S.B. 1815 was sponsored by Rep. Terry R. Parke (R-Hoffman Estates) and Sen. Joyce Holmberg (D-Rockford). ISMS did not oppose the legislation.

**Illinois trauma centers** will receive supplemental funding if the legislature approves changes recommended by the governor. H.B. 3884 provides for additional revenue to be distributed to hospital trauma centers, hospitals that qualify for critical care access payments and county hospitals. The new money would come from fees and fines collected from persons convicted of traffic violations. ISMS supported the legislation, which Edgar tentatively approved Sept. 24 pending changes to avoid potential conflicts with the hospital and nursing home assessment bill enacted last summer.

**Victims of domestic violence** will receive added protection under a bill Edgar signed Sept. 24. S.B. 400 expands the definition of domestic violence victims to include victims who have not cohabited with the alleged abuser, according to a spokesperson for Senate President Philip Rock (D-Oak Park), sponsor of the legislation. Previously, protective orders could be issued only to individuals who suffered abuse from a person with whom they cohabited. The legislation will affect mostly dating teens, which is the group that suffers the most from such abuse, said the spokesperson.

**A lead abatement bill** also got the governor's nod. Building on last year's legislation mandating lead screening of school children, H.B. 3638 parallels 1992 ISMS House of Delegates policy.

"The bill is significant in that it goes beyond outlining methodologies for recognizing and treating lead poisoning, and addresses means by which to control the most common sources of environmental occurrences of lead," said Jere E. Freidheim, M.D., ISMS Board of Trustees chairman, in a letter urging the governor's approval of the bill. "Of special note is the fact that this bill represents the combined efforts of the health

care community, citizens groups and Realtors."

The legislation was sponsored by Rep. Stepan and Sen. John J. Cullerton (D-Chicago).

**Medical residents in Illinois** are cheering Edgar's signing of S.B. 1692, which addresses regulation of resident and intern work hours. ISMS supported the amended bill, which requires all Illinois-licensed hospitals to meet Accreditation Council for Graduate Medical Education standards for resident and intern work hours.

"[ISMS] believes that work hour reform legislation, among other health care-specific issues, should be regulated and negotiated internally among all specialties in order to meet the needs of each group," said Dr. Freidheim in a letter urging the governor to sign the bill.

**Health care providers** who either notify or fail to notify a minor patient's parent or guardian about a positive HIV antibody test will be immune from civil or criminal penalties under legislation signed by the governor Sept. 15.

H.B. 4056, however, does require physicians and other providers to urge the patient to talk to his or her parents or guardian before the doctor can contact the parents about the test result. The ISMS-supported legislation was sponsored by Rep. Monique Davis (D-Chicago) and Sen. Margaret Smith (D-Chicago).

**Among several driving-under-the-influence bills** receiving the governor's approval was H.B. 3139, which provides that persons convicted of driving under the influence will be guilty of aggravated DUI when the drunk driving contributes to a vehicle crash that results in serious bodily harm. Under current law, drivers can be convicted of aggravated DUI only if the DUI solely caused the injuries.

"It is important that the state's attorneys be able to prosecute aggravated DUI cases to their fullest ability," Edgar said. "We must work to prevent needless injuries that are caused by thoughtless, selfish drivers."

**A seven-member Quality Care Board** appointed by the governor to help guide the operations of the Illinois Department of Mental Health and Developmental Disabilities Inspector General's office has been established under legislation approved by Edgar.

"The members of this board, which will include both professionals in the mental health field and persons with disabilities, will be able to lend their independent expertise to the department as we continue to work to improve the delivery of services to people who are mentally ill or developmentally disabled," Edgar said.

Members of the board will have experience or professional knowledge of law, investigatory techniques or care of the mentally ill or developmentally disabled. Two members will be people with a disability or parents of individuals with disabilities.

H.B. 3005 also reinforces the Inspector General's authority to conduct unannounced site visits at any state-operated facility and requires department employees to complete periodic training concerning preventing and reporting patient neglect and abuse.

The legislation was sponsored by Reps. Andrew J. McGann (D-Chicago) and Karen Hasara (R-Springfield), and Sen. Cullerton.

## YOCON<sup>®</sup> YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

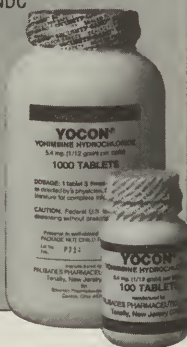
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# State and Chicago trauma systems alive and well

**TRAUMA SYSTEMS:** Despite some hospitals' withdrawals from the trauma system, Illinois has worked out most of the coverage kinks. By Janice Rosenberg

[CHICAGO] Approaching its sixth anniversary, the Illinois Trauma System is alive and well. Begun in September 1986 under the direction of the Illinois Department of Public Health, the system includes 12 Level I and 60 Level II trauma centers outside of Chicago, as well as six Level I trauma centers in Chicago. The Chicago trauma system, which began operation under home rule on May 1, 1986, became Region XI of the state system in December 1990.

According to Leslee Stein-Spencer, chief of emergency medical services for IDPH, the system is working well. "Each region has a plan in place. We have a trauma registry in place and are collecting data appropriately."

In the beginning, hospitals clamored to be designated Level I centers. In July 1988, when the state began designating centers, many communities had more than one interested hospital. "It's a commitment they give to their community, a good teaching tool, and a way of attracting residency programs and nurses," noted Stein-Spencer.

Level I centers are required by law to provide all essential services in-house 24 hours a day, and hospitals soon learned the expense of that requirement. Some were forced to rethink their zeal, due to the cost, and nine eventually left the system. Each region has found its own way of working out the coverage kinks.

For example, Region IV, covering the East St. Louis-Alton area, has no Level I center. Trauma patients who need tertiary care are sent to centers in Missouri. Alan Biggerstaff, ombudsman at St. Mary's Hospital in East St. Louis, pointed out that trauma cases do not go directly to St. Louis.

"They all go to a Level II hospital like ours first," he said. "We're only about 7 miles from Barnes Hospital [in St. Louis], so even though it's in another state, travel-wise [Barnes] is closer than some of the hospitals within our county. We work well with Barnes. Having to cross the river for a Level II hospital isn't a problem."

Terry Walther, vice president of Memorial Hospital in Belleville, agreed. His non-designated hospital has no problems with the trauma system arrangement in Region IV.

Region VI has also had to deal with geographical considerations. Covering 16 counties with a total population of more than 1 million, the region has a single Level I center – the Carle Foundation Hospital in Urbana – and three Level II centers – Decatur Memorial Hospital, St. Mary's Hospital in Decatur, and

United Samaritans Medical Center in Danville. St. Anthony's Memorial Hospital in Effingham and Sarah Bush Lincoln Health Center in Mattoon, both Region VI hospitals with high patient volume, dropped their Level II designations in 1991.

"Even in an ambulance going 75 miles per hour, Effingham is an hour and 45 minutes from Urbana," said Mary Beth Myers, trauma coordinator for Region VI. "It's a long way to go for a Level I center, so people have to be stabilized down there. In that way, St. Anthony's is still involved in the trauma system as an affiliate trauma hospital, as are the 12 other noncenter hospitals in our region."

According to Myers, the system works well. "We have lots of feedback between the trauma centers and the affiliate trauma hospitals," she said. "We're a close, flexible group, and we provide good patient care through constant networking, follow-up, follow-through and education."

Joyce Cottingham, director of the emergency department at Sarah Bush Lincoln Health Center, said the center's staff is not treating trauma patients any differently than they did when they were a Level II center. "Whatever the patients need as far as stabilization and treatment, we do. If they need a higher level of treatment, we send them to Urbana."

**LEVEL I CENTERS** must still contend with cost. In Region I, Rockford Memorial Hospital and St. Anthony Medical Center are both Level I centers. "The system works, but it's expensive," said Jerome S. Weiskopf, M.D., president of the

Winnebago County Medical Society. "There's a lot of duplication of services. Both hospitals have empty trauma beds regularly. Both are paying big bucks to have nurses on call, and they're not utilizing them."

Raymond E. Hoffmann, M.D., a general surgeon at St. Anthony, agreed. "Our concern is that the care was good before the hospitals became Level I centers, and the care is still good, but now we're spending a lot more

money to provide it."

Hospitals in Region III have taken a different approach to the same problem. Region III operates with five Level II centers and no Level I center. This is possible because of a cooperative effort between St. John's Hospital and Memorial Medical Center in Springfield – both large Level II tertiary centers in Region III – and Southern Illinois University Medical School, which provides residents and physicians to St. John's and

## Illinois trauma centers

REGION I		CITY, LEVEL		REGION VIII	
Rockford Memorial Hospital	Rockford	I		St. James Hosp. Medical Center	Chicago Hts. II
Mercy Health Center	Dubuque, IA	II		Riverside Medical Center	Kankakee II
Freeport Memorial Hospital	Freeport	II		Silver Cross Hospital	Joliet II
Saint Anthony Medical Center	Rockford	I		Palos Community Hospital	Palos Heights II
SwedishAmerican Hospital	Rockford	II		Morris Hospital	Morris II
Finley Hospital	Dubuque, IA	II			
REGION II					
Galesburg Cottage Hospital	Galesburg	II		MacNeal Hospital	Berwyn II
Brokaw Healthcare	Normal	II		Edward Hospital	Naperville II
St. Mary's Hospital	Galesburg	II		Foster G. McGaw	Maywood I
United Medical Center	Moline	II		Glen Oaks Medical Center	Glendale Hts. II
Saint Francis Medical Center	Peoria	I		LaGrange Memorial Hospital	LaGrange II
St. Joseph's Hosp. Med. Center	Bloomington	II		Central DuPage Hospital	Winfield II
Proctor Community Hospital	Peoria	II		Gottlieb Memorial Hospital	Melrose Park II
Pekin Memorial Hospital	Pekin	II		Good Samaritan Hospital	Downers Grv. II
Methodist Medical Center	Peoria	II		Hinsdale Hospital	Hinsdale II
REGION III					
St. Mary Hospital	Quincy	II		REGION IX	
Passavant Area Hospital	Jacksonville	II		Copley Memorial Hospital	Aurora II
Blessing Hospital	Quincy	II		Northwest Community Hospital	Arlington Hts. II
St. John's Hospital	Springfield	II		Northern Illinois Med. Center	McHenry II
Memorial Medical Center	Springfield	II		Good Shepherd Hospital	Barrington II
REGION IV				Holy Family Hospital	Des Plaines II
Wood River Township Hospital	Wood River	II		Lutheran General Hospital	Park Ridge I
St. Mary's Hospital	East St. Louis	II		Saint Joseph Hospital	Elgin II
Alton Memorial Hospital	Alton	II		Sherman Hospital	Elgin II
Saint Anthony's Hospital	Alton	II		Mercy Center	Aurora II
Barnes Hospital	St. Louis	I		Memorial Hospital	Woodstock II
St. Louis University Med. Ctr.	St. Louis	I		Alexian Brothers	Elk Grove Vlg. II
Christian Hospital NE	St. Louis	II		Humana Hospital	Hoffman Est. II
REGION V				Delnor-Community	Geneva II
Memorial Hospital	Carbondale	II		REGION X	
REGION VI				Highland Park Hospital	Highland Park II
St. Mary's Hospital	Decatur	II		Rush North Shore Med. Center	Skokie II
Decatur Memorial Hospital	Decatur	II		Condell Memorial Hospital	Libertyville II
Carle Foundation Hospital	Urbana	I		Evanston Hospital	Evanston I
United Samaritans (Logan)	Danville	II		Glenbrook Hospital	Glenview II
REGION VII				St. Therese Medical Center	Waukegan II
St. Joseph Medical Center	Joliet	II		Lake Forest Hospital	Lake Forest II
St. Mary's Hospital	Kankakee	II		St. Francis Hospital	Evanston I
South Suburban Hospital	Hazel Crest	II		REGION XI	
Christ Hospital	Oak Lawn	I		Illinois Masonic Hospital	Chicago I
Olympia Fields Ost. Med. Ctr.	Olympia Fields	I		Northwestern Memorial Hosp.	Chicago I
				Cook County Hospital	Chicago I
				Mt. Sinai Hospital Medical Ctr.	Chicago I
				Children's Memorial Hospital	Chicago I
				Wyer Children's at the	
				University of Chicago	Chicago I

Memorial. Physicians from the community are also involved.

"We said we could be Level I's and spend the money for a surgeon in-house, or we could both be Level II's and still give our patients excellent care," explained David Griffen, M.D., medical director of emergency medical services at Memorial. "It's a short driving distance to the hospital from anywhere in Springfield. A Level II hospital with our capability can handle any kind of trauma patient. Just to have someone sleeping here doesn't impact on patient care."

**IN CHICAGO, HOSPITALS** originally expected to profit on trauma. Under the Chicago Department of Health, the city system started with 10 Level I centers. "That was a lot more than we needed," said Robert Smith, M.D., medical director of the trauma program for CDOH. "But hospitals thought if they weren't designated and a nearby hospital was, they would lose prestige and patients."

Instead, hospitals quickly found themselves losing money. Many trauma victims are uninsured. Others' bills were paid by the government. "If a patient has Medicare or Medicaid, at least you're getting some money, but it's reliably less than the costs of delivering care," said Dr. Smith.

Several hospitals pulled out of the system. Remaining today are four adult centers – Illinois Masonic Medical Center, Cook County Hospital, Northwestern Memorial Hospital, and Mount Sinai Hospital Medical Center – and two

pediatric centers – Children's Memorial Hospital and Wyler Children's Hospital at the University of Chicago. Lutheran General Hospital in Park Ridge and Christ Hospital and Medical Center in Oak Lawn are in other state regions but, by agreement, treat city trauma victims.

"The good news is we're still in business," said John Barrett, M.D., director of the trauma center at Cook County Hospital. "We're still maintaining ground transportation times of no more than 20 or 30 minutes from any point in the city to a Level I hospital. And the rate of preventable trauma deaths is only 2 percent – as good as anywhere in the country." Still, he said, the loss of hospitals has left the system "tight as a bowstring."

The major problem – a shortage of Level I centers on the South Side – forced CDOH to look closely at the system. Ideally, triage for trauma victims is done at the nearest trauma center. Following this rule – without Michael Reese and the University of Chicago – Christ Hospital became responsible for about one-third of the city geographically and about one-half of all the trauma cases.

To remedy the situation and prevent Christ Hospital from being overwhelmed, CDOH deviated from the "nearest center" rule. The three mid-city trauma centers – Mt. Sinai, Northwestern and Cook County – were given geographical "catchment areas" that dip down into the southern part of the city. Instead of going to the nearest center –

(Continued on page 22)

*"A Level II hospital with our capability can handle any kind of trauma patient. Just to have someone sleeping here doesn't impact on patient care."*

– DAVID GRIFFEN, M.D.



# Illinois Medicine

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## EDITORIAL

# Naming names

Why does *Illinois Medicine* publish disciplines? There is no easy answer to that question. The policy has been reviewed at least once a year, usually in response to queries from physicians who have been disciplined by the Illinois Department of Professional Regulation, the state agency that provides this newspaper with the information we reprint. To the doctor who has confronted the disciplinary process, publication of his or her name in *Illinois Medicine*, of all places, seems like adding insult to injury. How can *Illinois Medicine* justify publishing these names?

We do it in the name of the big picture. We do it in the interest of physician self-regulation and peer review. And ultimately we do it because every time we ask the question, the answer is: "Because it's the right thing to do, that's why."

Because we must, as professionals, take a strong and public stand on the right and responsibility of medicine to police and discipline physicians.

ISMS supports a sound investigative and disciplinary function, with physicians actively involved in the entire process. That's an important enough point to reiterate: Disciplinary questions are asked by and disciplinary measures are recommended by physicians in IDPR. In the IDPR process, physicians are reviewed, judged and disciplined by physicians working within the framework of state law, and working alongside state officials whose responsibility is

to enforce state law.

The Society supports that process, and even lobbied to raise licensure fees to provide the revenue to increase those efforts several years ago.

No less a critic of medicine than Sidney Wolfe of the Ralph Nader organization Citizen's Action in Washington had to grudgingly give credit to the medical profession in Illinois for the profession's – and the Society's – role in policing itself and supporting state disciplinary activities.

But it's not enough to say we do it because if we don't, Sidney Wolfe will. We do it because we believe in and support the concepts of physician peer review and state – not federal – regulation of medicine.

We print the information exactly as it is received from IDPR. We do not, for example, omit the names of those doctors who are disciplined because they were late in renewing their licenses.

If we did, the next step would be to exclude the names of doctors who commit some other "minor" infraction – and it's a slippery slope from there on.

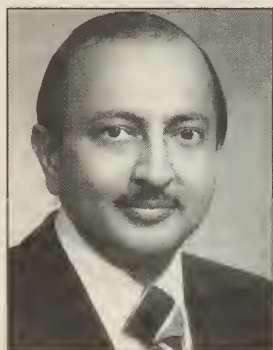
So we publish disciplines because it's the right thing to do. To not do so would be to open the door, just a crack, to other self-declared experts who would like to take over the medical review and discipline process.

More important, we publish disciplines because professionalism – guarding the high standards of medical care – is our most important asset.

## PRESIDENT'S LETTER

# Together we stand, divided we are stuck – so are our patients

By Arvind K. Goyal, M.D.



*"Family practitioners are able to do a better job when they have access to specialty consultants."*

A nurse in labor and delivery wondered why a medical student was so enthusiastic about obstetrics. He responded sheepishly, "When I was on medical rotation I often suffered from asthma. In surgery I was sure I had appendicitis more than once. On psychiatry I thought I was losing my mind. Now, in OB, I can relax."

I remember similar experiences, once having itched a whole night away after seeing a patient with scabies. In family practice, being the specialty of breadth it is, we go through these seesaw feelings in a rotating manner all our professional lives.

There are yet other practice differences amongst specialties. In my suburban solo practice I get to know most of my patients too well. A majority of the ones I call good patients, listen intently, ask questions, write notes to themselves, and, once convinced, do everything their doctor tells them. Other patients are willing to do everything to a certain point – but will not go to a hospital or a specialist. I got nervous when one friendly patient informed me, "I am married to you, doctor. Now don't ask me to go around town." It is tough to reason with them, to tell them why I am not an expert at everything. A handful of patients come to me for their well-care, minor ailments and colds, but ask for referral to a superspecialist for everything that requires "brains," sometimes "hands." We argue, we discuss alternatives, but eventually most patients leave "winners." Those that don't get their way hopefully leave informed as to why winning may not be in their ultimate interest.

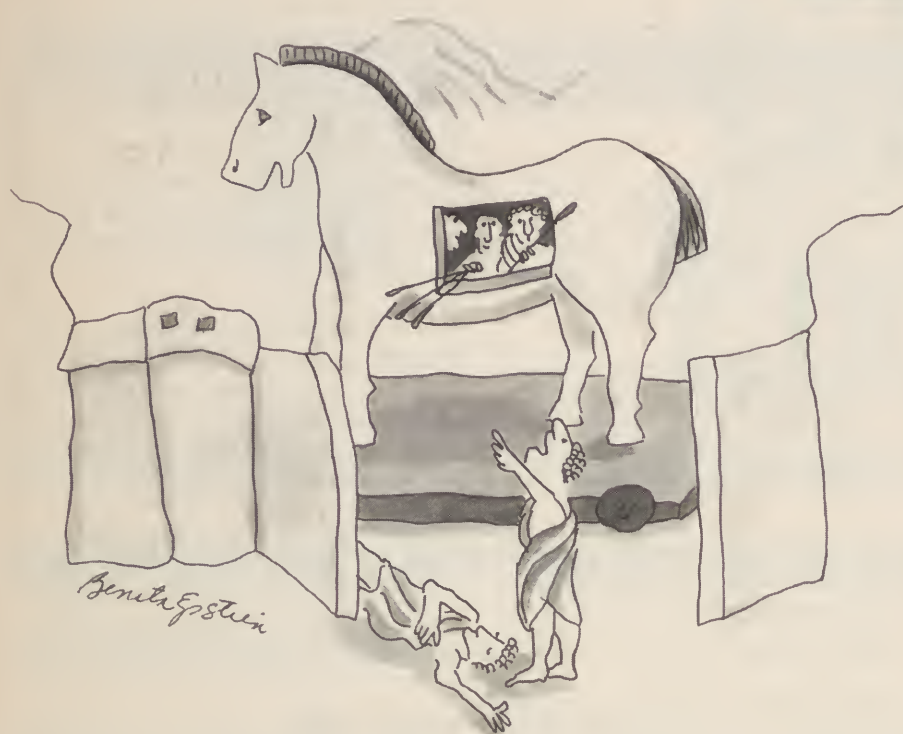
In the current health care reform debate, more than once an increase in physician specialties has been blamed for anything and everything. Excessive specialization into non-primary care specialties, some will say, is responsible for imbalance in physician distribution, lack of access and rising costs. Only about a third of U.S. physicians are generalists compared to more than half in Canada,

Britain and Australia. And finally, some family practice colleagues tell me, they work more and inconvenient hours and for less money – in spite of RBRVS! They don't believe for a moment that the world is a fair place.

Time now to count our blessings. Increasing specialization is associated with advances in medical science and technology. That clock should not be turned back. Many benefit from opportunities for education afforded by specialty consultations and discussions on a continuing basis. My horse sense tells me that family practitioners are able to do a better job when they have access to specialty consultants when needed, albeit at increased but necessary costs. If things change for the worse in a patient I follow, if an emergency surgery becomes necessary, my consultants come God-sent, and quickly. It may be that primary care physicians are reluctant to settle in those isolated areas where support specialists are not readily available. Most importantly, a good working relationship between primary care and consulting specialists benefits patient care quality.

No question, we need more physicians – generalists and specialists – willing to fill the existing gaps in medical services. All medical schools ought to enrich their students' experiences by making sure that exposure to family practice and community health is included in their medical school curriculum. The specialty residency experiences similarly must be broadened to preserve a continuing ability to provide basic medical care. Motivation, service and dedication, not reimbursement levels or loan deferment schemes, should dictate the choice of specialties physicians train in. We need good physicians everywhere in Illinois – I just learned they're looking for an orthopedic surgeon in Jacksonville, an Ob/Gyn in Kankakee, a pathologist in Galesburg, a pediatrician in Joliet, and a general surgeon in Macomb. Many Illinois communities are looking for internists and family practitioners.





"Is there a doctor in the horse?"

## LETTERS

### The more you know, the more you don't know

A clarification is in order regarding my President's Letter published in *Illinois Medicine* Sept. 11, 1992, "Immunization Increases Costs But Saves Lives."

Dr. Joan Meyer, respected pediatrician and esteemed friend, humbled me by pointing out that the cost for hepatitis B vaccine would be lesser for newborn and pediatric patients, since they require a smaller dose. The point still remains: Since we have not succeeded in assuring a 100-percent compliance with already recommended immunizations, is it practical, cost-efficient and wise to keep enlarging the list of required immunizations?

I am ever so thankful to Dr. Meyer for reading my column and for her comments.

— Arvind K. Goyal, M.D.  
ISMS president  
Rolling Meadows

### So many drug reps, so little time

Having had a standing order in my office to see one detail man a day for four days a week for 35 years, I feel qualified to answer the guest editorial by the unnamed detail man.

In 1957, I could see almost all of the different reps in one month by seeing one rep a day, four days a week. Now we have new company divisions coming on about two times a month. You see, Eli Lilly used to have one man; now they have two: one selling the insulin products and the other selling old products. This has now spread to the point that if I saw three reps a day for the 20 days of the month, I might not get through

all of the different companies that have representatives in my territory.

Secondly, if you are really interested in learning something about antibiotics, for example, you can get an unbiased opinion from TV's Lifetime or Audio Digest or medical newsletters. It's very unlikely that you will get an unbiased opinion about the proper antibiotic to be used on, say, a two-year-old with otitis media, from a salesman pushing Augmentin.

Thirdly, about two-thirds of the visits are to tell me about a new calcium channel blocker or another "me too" ace inhibitor. For example, right now we have three forms of glyburide; yes, three different salespeople, and there aren't two snaps of difference between them. Isn't that a waste of time?

There are more salesmen, more products and more companies, so I have less time to see them.

I'm sorry, but if I want unbiased knowledge — the only kind worth knowing — I have to look elsewhere.

Yes, I'll still see you, mainly because I feel sorry for you — as you are caught between the big, greedy drug companies that have seemingly never heard of increasing their market share by cutting their prices and the doctors with limited time.

— James E. Gottemoller, M.D.  
Streator

*Illinois Medicine welcomes letters on topics of interest to our readers. Write us at Letters to the Editor, Illinois Medicine, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602 or fax (312) 782-2023. Letters of any length will be considered for publication, but we reserve the right to edit for space.*

## GUEST EDITORIAL

# Election '92: Decide your own future

Since well before the March primary, we have been "beating you over the head" with the importance of Election '92 as it relates to redistricting in our state. Once again I'd like to stress that Illinois' new legislative map and the fact that we are electing an entirely new General Assembly present an incredible opportunity for medicine. We have the chance to build a "medical majority" of legislators from both parties in both the state House and Senate that realizes the challenges of practicing medicine today. Although this opportunity is indeed golden, one thing can tarnish it.

"Only about 50 percent of physicians in the state of Illinois are registered to vote," said Rep. David Deets, M.D. (R-Dixon) during an interview for a video for the Illinois State Medical Society Political Action Committee. "And of that 50 percent, only half of them do vote ... so one out of four physicians takes the time and interest to vote in the state of Illinois."

In other words, 25 percent of the physician population in Illinois is making decisions on behalf of the entire medical profession — decisions about the legislators who represent us in Springfield and Washington, and ultimately about the public policy affecting you and your practice. You don't let anyone else decide your patients' medical treatment, so why would you let others decide the future of your profession?

The most important thing you can do for yourself and your patients is to vote this November. Once you've registered, find out who is running for office in your area. Your legislative district will be printed on your voter registration card, but if you'd like to know right away, you may call the ISMS Governmental Affairs staff at (800) 782-ISMS. They can tell you about the districts in which you live and work, and who is running for office in the Illinois General Assembly and the U.S. Congress. ISMS has a pretty good idea of which candidates are friends of medicine and which are supported by physicians in your community.

Get involved in that candidate's campaign. It really doesn't take a lot of time to be an integral part of a campaign. If you want to start slowly and test the waters, call the campaign office and ask to have a sign placed in your yard. Request a supply of the candidate's printed materials and display them in your office waiting room (if your office is in that candidate's district). Offer to sign a letter with other community physicians in support of the candidate. If you'd like to spend a little more time, offer to go door-to-door to talk to your neighbors about the candidate. Introduce the candidate at a hospital

medical staff meeting. Host a coffee for the candidate. There are many ways to get involved. The quickest way is writing a check — that extra financial support is always useful.

These actions are invaluable to both the candidate and you as a physician. The candidate has you — a well-regarded member of the community — on his or her side. When that candidate takes office, you will have an established relationship with a policymaker who will listen to your views on important issues.

*"We have the chance  
to build a 'medical  
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realizes the challenges  
of practicing medicine  
today."*

There's another important way to influence the outcome of this year's elections. You can contribute to IMPAC, which supports candidates who share medicine's views on health care and who are supported by physicians in that community. IMPAC support has frequently been the deciding factor in elections, but we can be successful only if all physicians pitch in and do their share. I urge you to be a part of the movement to preserve and enhance quality health care for your patients by contributing to IMPAC, working on a campaign and voting.

Remember, only one in four Illinois physicians takes the time to vote. Imagine the voice physicians would have, the impact physicians could make, if each and every one of us and our spouses went to the polls on Election Day and got just the least bit more involved in the political process. The possibilities are endless.



**George T. Wilkins Jr., M.D.**, is the chairman of IMPAC. To contribute to IMPAC or to receive more information, call (312) 782-1963.

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## IDPR DISCIPLINES

*This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.*

**March 1992**

Lucille I. Damasauskas, Chicago – physician and surgeon license reprimanded after allegedly engaging in unprofessional conduct.

Roger Watters, Chicago – controlled substance license reinstated on probation following one year suspension after Department alleged in 1990 that controlled substances had been improperly prescribed to some patients and Controlled Substances Dispensing Log had been improperly maintained.

Sala Chanpong, Mount Prospect – physician and surgeon and controlled substance licenses revoked after convicted of felony relating controlled substances and alleged distributing and dispensing of controlled substances for nontherapeutic purposes.

Farzana Butt, Chicago – physician and surgeon license reprimanded and fined

\$2,000 after convicted of felony for aiding and abetting use of false documents in U.S. District Court in Peoria.

Thomas E. Radecki, Decatur – physician and surgeon and controlled substance licenses revoked for a minimum of five years after engaging in immoral conduct of unprofessional nature with patient.

**April 1992**

John C. Somberg, Lake Forest – physician and surgeon license reprimanded and fined \$1,500 after State of New York license disciplined for allegedly making and filing false report.

Gregory Calkins, Wheaton – physician and surgeon license reprimanded after several states disciplined license following 1987 conviction for income tax evasion.

Michael L. Treece, Murphysboro – physician and surgeon license placed on probation for one year and fined \$2,500 after alleged improper prescribing and recordkeeping involving controlled substances.

**May 1992**

Robert J. Darga, Washington, D.C. – physician and surgeon license revoked for minimum of five years after discipline by state of Maryland on underlying charges of sexual misconduct.

Mahfouz Habib Rizk, Bourbonnais – physician and surgeon license reprimanded after failing to control gestational diabetes although board certified as obstetrician and gynecologist.

Ellen Millstein, Abbot Park – physician and surgeon license reprimanded and fined \$950 after failing to renew license in timely manner.

Kenneth Hatfield, Chicago – physician and surgeon license suspended indefinitely and controlled substance license revoked for minimum of five years after writing prescriptions for controlled substances in exchange for sexual favors.

Herbert Gutierrez, Decatur – physician and surgeon license reprimanded and fined \$5,000 after prescribing controlled substances without proper licensure.

Ronald M. Tauber, Atlanta, Georgia – physician and surgeon license revoked for minimum of five years after discipline by state of California for criminal conviction in 1982.

David Lyn Sturdivant, Lake Park, Florida – physician and surgeon license revoked for minimum of five years after discipline by state of Florida for aiding and abetting unlicensed practice of medicine.

Virgilio T. Guzman, Glen Carbon – physician and surgeon license placed on probation for three years after allegedly failing to properly monitor postoperative recovery of patient.

**June 1992**

Milton Daugherty, Chicago – physician and surgeon license reprimanded and fined \$5,000 for prescribing controlled substances without possessing current, valid controlled substance registration.

Robert Lewis Farner, Toluca – physician and surgeon license placed on probation for two years after allegedly committing gross negligence in treating various nursing home patients.

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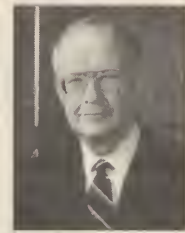
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ISMIE  
BOARD  
BRIEFS

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ISMIE  
Update

An action  
plan for  
service  
excellence

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## Exchange initiative underscores service to policyholders

**SERVICE INITIATIVE:** ISMIE Board renews commitment to better service to policyholders.

[ CHICAGO ] "Physician First Service" is the new watchword for the Illinois State Medical Inter-Insurance Exchange Board of Governors following the Board's sign-off on a plan designed to improve policyholder service. The "Focus on Service" initiative will provide malpractice insurance to physicians as not just a product, but also as a service. The Exchange Board began the initiative in April of 1991, and since then has developed specific activities to place the policyholder first in every phase of company operation.

"Policyholders own the Exchange and expect to be treated like owners," said Harold L. Jensen, M.D., Exchange Board chairman, from Harvey, at an all-employee meeting Sept. 24. "The Exchange Board demonstrates its willingness to support service."

"The board will play a key role in reaching out to policyholders and taking our company to them," Dr. Jensen continued. "What the board has indicated is that policyholders will get what they want — a solid financial company that is technically competent and that will give them the protection and service they expect."

"The ISMIS Board of Directors will play a very important part in the service initiative," said Phillip D. Boren, M.D., ISMIS Board chairman, from Carmi. "Employees of all levels, including front-line employees, began building the service commitment throughout the year." Work groups that crossed divisional lines tackled every phase of company operation, analyzing and making recommendations for service improvement.

A cornerstone of the plan involves physician leaders' reaching out to policyholders, including a strategy for Exchange physician leaders to visit with policyholders in their local communities. The company will meet with physicians of all specialties throughout the state to serve their malpractice needs. "This plan involves physicians serving physicians,"

said Boyd E. McCracken Sr., M.D., ISMIE Board member, from Greenville. "Policyholders will see me and other members

*"We want to make  
a good company  
even better by  
making excellent  
service a permanent  
operational  
component."*

**HAROLD L. JENSEN, M.D.,  
EXCHANGE BOARD  
CHAIRMAN**

of the board on their home ground, listening to their concerns and talking to them about how ISMIE can help them."

Research showed that policyholders know and trust the Exchange because they know and trust physicians involved in the company. "When I travel around the state for our Exchange risk management programs, I recognize how important it is that board members play an active role in promoting the company," said Jere E. Freidheim, M.D., ISMIS Board chairman and ISMIE Board member, from Chicago. "It's important to be out there answering policyholder questions about the company. When we are face-to-face with policyholders, we are the company."

**ANOTHER MAJOR ELEMENT** in the plan is the continuous tracking of service quality. Policyholders will be surveyed to see if company service has met their expectations. "We know that excellence in any effort requires internal scrutiny," said Robert

M. Reardon, M.D., ISMIE Board member, from Bloomington. "That's why we have built into this plan ways to evaluate the quality and speed with which policyholders have been served by the company."

The plan calls for a major commitment to better serve policyholders in all of Illinois through regional offices staffed by underwriting and claims personnel. "We tested the concept of regional offices when we set up the Springfield office, and it has been very successful," said Fred Z. White, M.D., ISMIE vice chairman, from Peoria. "We want to say to the downstate physician, 'we care about you.' Claims and underwriting services in regional offices will be offered for the convenience of policyholders. That's what the service initiative is all about: Making malpractice protection as hassle-free as possible."

Aggressive defense of claims

has always been the Exchange's philosophy and practice. As part of the service initiative, the board scrutinized every step in Exchange claims handling. What emerged is a physician-centered claims defense strategy. "When doctors are sued they are under tremendous tension and pressure," said Henri S. Havdala, M.D., ISMIE Board member from Chicago. "The suit is on their mind, always. With this initiative, someone is going to be in continual contact with sued physicians and doctors will know that someone is looking out for them."

Alan M. Roman, M.D., ISMIE Board member and Chicago Medical Society president, added that the plan is designed for policyholders who haven't been sued, and so may have limited contact with the Exchange. "We want them to know we're there whether they need us or not, and will be there when they do need us," said Dr. Roman. "Policyholders tell us they value our commitment."

**A NEW PHONE SYSTEM** will allow policyholders to communicate essential information via electronic messaging. "I was skeptical about introducing anything that would take away from personal service," said Edward J. Fesco, M.D., ISMIE Board member, from LaSalle. "But the Exchange's new system is going to be the best of both personal and electronic service. We'll eliminate telephone tag for policyholders and give them options to communicate vital information to the company."

"Most of our policyholders want us to make the problem of malpractice go away," said Dr. Jensen. "We also protect the tort reforms we won in 1985 and 1987 through vigilance in the courts."

"Changes like this don't take place overnight," Dr. Jensen said. "It takes a long time to instill a different culture in a company. We have always been a good company. Our policyholders have been very satisfied with our company's sound fiscal condition, aggressive defense of claims and tough underwriting. We want to make a good company even better by making excellent service a permanent operational component." ■

### Patient conditions that lead to the largest insurer payouts

Condition	Paid claims	Total indemnity payout	Average indemnity
1. Breast cancer	542	\$100,508,200	\$185,440
2. Fetal distress	209	67,298,100	322,000
3. Brain-damaged infant	108	51,481,500	476,680
4. Acute myocardial infarction	293	50,410,000	172,050
5. Cerebral palsy, infantile	97	45,816,700	472,340
6. Cancer of bronchus or lung	306	41,277,200	134,890
7. Pregnancy	402	37,540,500	93,380
8. Meningitis	139	37,492,500	269,730
9. Displaced intervertebral disc	242	34,819,600	143,880
10. Central nervous system complication of procedure	71	33,592,800	473,140

\* Based on results of 78,712 claims of the PIAA Data Sharing Project, accumulated between Jan. 1, 1985, and June 30, 1991. This is not a statistically valid survey based on random-sampling techniques.  
Source: Physician Insurers Association of America.



## THE CHAIRMAN'S PERSPECTIVE

## An action plan for service excellence

The Sept. 11 Exchange Board meeting marked both an end and a beginning. That day, my colleagues on the board reviewed and approved a comprehensive new plan of activities designed to improve service to Exchange policyholders. Guided by the board, but written by staff from all levels, the plan was 15 months in the making.

When I first became chairman of the Exchange in April of 1991, I viewed my challenge to be how to make a very good company better. As a result of Dr. Fred Z. White's chairmanship in the decade before me, ISMIE is a financially sound, stable company. During the 1980s Dr. White successfully fought for tort reform and won everything but a cap on noneconomic awards. Also during that decade, in order to remain financially viable in today's malpractice climate, the company successfully changed from occurrence to claims-made coverage. Many tough actions were taken that showed that ISMIE is committed to providing the best liability protection for Illinois physi-

cians and can weather tough times to stay strong.

Where could ISMIE improve? It seemed to me that ISMIE's drive for excellence should come in the area of service to policyholders. Over the years, I have heard very few complaints about ISMIE. Most physicians have viewed ISMIE, and indeed the whole area of liability protection, as something you have to buy, but you hope you never have to use.

The Exchange Board agreed that excellence in policyholder service would make ISMIE more than just a good, reliable, solid company. It would make it a great company. We began by asking policyholders, board members and staff what good service is and how we could improve our own service performance. In June of 1991, our research told us what good service is. Our policyholders expect high competence, stability, and a proactive advocacy from physicians who are involved in the company and the staff.

With guidance and direction from the board every step of the way, a plan was

formulated to infuse the service attitude throughout the company, at all levels. The plan is broad, ranging from the quality of claims handling to the quality of telephone service. The plan is designed for permanency. Many of the activities planned have a three-year or more phase-in period, before becoming an integral part of the organization. The plan is deep, reaching into all levels of company staff for improved service, and moving to the highest levels of senior management.

This program of applied excellence won't work without strong commitment from the Board of Governors. The board expressed that commitment at the September meeting, when they enthusiastically and wholeheartedly said yes to the plan's specifics. With that affirmation, the board ended the year of research and planning, and began an important new phase: implementation and action.

We hope you have already seen signs of ISMIE's service improvement. In the coming months and years, you'll see more. Our pledge to policyholders and potential policyholders is that we have built a permanent service element into this company so that excellent service is always a "given" with ISMIE. I expect to hear from you if it isn't.



**Harold L. Jensen, M.D.,** is chairman of the Exchange Board of Governors.

## AMA warns about Data Bank response group

[ CHICAGO ] The American Medical Association recently met with members of a new organization that calls itself a "counterbalance" to the National Practitioner Data Bank. AMA legal staff was alerted to the group – called the National Practitioner Data Bank Response Association – when they discovered that for a \$250 fee, the organization says it will send, in addition to federally authorized Data Bank forms, its physician members' explanations of malpractice claims to entities that query the Data Bank.

The AMA became aware of the group through a mass mailing from the NPDBRA. The AMA discovered that the group is not an association and does not offer a number of services it has advertised, such as a newsletter and lobbying support. It does offer an analysis of members' malpractice claims; however, the AMA warns that such a rating may be viewed as unverified or self-serving since the rated information comes from members themselves.

The Health Resources and Services Administration Bureau of Health Professions released a report saying the group "appears to be a gimmick to identify high-risk physicians [in order] to sell them high-risk insurance." The AMA urges physicians to consult their attorneys before investing in the service. For more information, contact the AMA Office of the General Counsel at (312) 464-4606. ■

## MALPRACTICE ROUNDUP

## President pushes malpractice cap bill

Citing rising health care costs caused by medical malpractice suits and "defensive" medicine, the Bush administration proposed legislation to Congress that would pressure states to place a \$250,000 cap on noneconomic damages. As reported in *Medical Liability Monitor*, states would have the option to reject the legislation but could face heavy penalties on discretionary funds they receive.

The bill also would eliminate a rule allowing patients to collect a second time from jury awards for bills already paid by insurance and would limit a rule allowing patients to sue anyone involved with the case and collect from the wealthiest party, regardless of blame.

Talbot D'Alemberte, immediate past president of the American Bar Association, said the bill would do nothing significant to reduce health costs, and the focus should instead be on reforming health care delivery and access.

## Interns and standard of care

A recent issue of the *Malpractice Reporter* questioned whether first-year interns should be held to the same standard of care as doctors who have completed their residencies. At an Indiana hospital, two interns possessing temporary medical permits allegedly negligently administered lithium to a patient, causing seizures and severe neurological damage.

Under the Indiana Medical Malpractice Act, the interns did not qualify as "physicians," but as they were employees or agents of the hospital when the alleged malpractice occurred, they fell within the Act's definition of "health care providers."

According to the *Malpractice Reporter*, both

interns presented themselves as doctors to members of the public; they called themselves doctors, and the hospital referred to them as doctors. They made no representation to patients that they possessed less skill or knowledge than that of medical practitioners. Therefore, by definition of the practice of medicine in the medical malpractice statute, they would both be held to the standards of any other medical practitioners.

## TV in the office

Visual aids can be important in obtaining informed consent, the *Physicians Financial News* noted. The publication reported that some physicians ask patients to watch videotapes of the doctor reading aloud informed consent agreements for specific procedures. This method saves time, especially for physicians who tend to perform the same procedure.

Other physicians show patients educational videos about procedures, quizzing them afterward to make sure they understand the risks. A third method of assuring the patient is adequately briefed is taping each informed consent session.

The latter method has spurred some debate. Lawyers have found the practice to be "intrusive," and, according to the article, physicians who inadvertently omit risks or communicate ineffectively could create liability. Another strike against taping each session is that it could cause a jury to believe physicians are trying to protect themselves from their patients.

## Responding to an adverse event

According to *Forum*, the publication of the Risk Management Foundation of the Harvard Medical Institutions Inc., expressing sincere sympathy and

compassion is often the most important response a physician can make to a serious adverse event. The health care team should not become defensive, but should instead begin alleviating a potentially volatile situation.

The publication advises a team to keep communicating with the patient and family, and to remember that repeated requests for an explanation are a common reaction. The health care provider should empathize with the patient and family and try to reconcile any differences in opinion as to what has occurred. The provider should also accept responsibility for follow-up of serious complaints, but should not accept or assign blame, nor criticize the care or response of other providers.

Finally, the health care team should contact the institutional risk manager and complete any reporting requirements (potential claim, medical device failure, etc.); it is important to avoid writing any information unrelated to the care of the patient (e.g., "incident report filed," "legal office notified") in the patient's record. Serious adverse events should also be reported to your malpractice insurer.

## Do you deliver?

According to a March of Dimes study, 70 percent of family physicians have stopped delivering babies, *Medical Liability Monitor* reported. The reason, the study found, is fear of litigation and the high costs of liability insurance.

One in six obstetricians has quit the practice, the study showed. Seventy percent of the doctors who stopped delivering said they would start again only if awards were capped.

Poor women were shown to suffer the most from the declining availability of doctors. ■



## EXCHANGE Q &amp; A

**Q. What is the status of ISMIE's coverage for orthopedic surgeons?**

A. In 1992, orthopedic surgeons who do not perform back surgery remained in Class 6 because their losses have neither increased nor decreased. Last year, a new class – Class 6A – was created for orthopedic surgeons who perform back surgery, lowering their rate 12 percent. These physicians were previously rated Class 7.

**Q. Does the Exchange provide incentives for loss-free experience?**

A. This year the Exchange introduced a new program that rewards physicians who have loss-free experience. Policyholders who have gone without a paid loss for three continuous calendar years receive a 3-percent credit on their base premium. For each additional year without a paid loss, another 1 percent is discounted, up to a maximum of 10 percent for 10 years or more of loss-free experience.

**Q. If I go on maternity leave, can I reduce the premium on my Exchange policy?**

A. It is possible to place your policy on suspended coverage, which is an inactive status, for a period of at least 30 consecutive days but not more than 12 consecutive months.

While on suspended coverage, you have coverage for any claims reported from previous acts. There is no coverage, however, for any direct patient care. The premium required is 25 percent of your current ISMIE quarterly premium. Your written request is required to place your policy on suspended coverage, as well as to reinstate full active status.

Suspended coverage applies to several other situations, such as vacation, continuing education and illness. For more information about suspended coverage, contact the Underwriting Division.

**Q. Do I need admitting privileges at a hospital to obtain an insurance policy with the Exchange?**

A. Yes. All applicants and insureds are required to maintain admitting privileges for at least one hospital. These are exceptions based on various medical specialties. Policyholders can contact the Underwriting Division for further clarification.

**Q. What is a Certificate of Insurance, and how can I request one?**

A. A Certificate of Insurance confirms that the Exchange has issued a policy to the named insured. Hospitals and employers often request verification of insurance coverage, and the certificate fulfills that need.

Requests for certificates, including policy numbers, should be submitted

in writing to the Underwriting Division by the named insured. They can be forwarded directly to the policyholder, or to a designated individual or organization. A new certificate is automatically issued when the annual policy is renewed or liability limits are altered.

Send your questions to Exchange Q&A, Illinois Medicine, Twenty North Michigan Ave., Suite 700, Chicago, Ill. 60602



"I think you two will enjoy each other immensely. However, I am in no way liable for any pain, suffering, loss or damage caused by, or alleged to result from, this introduction."

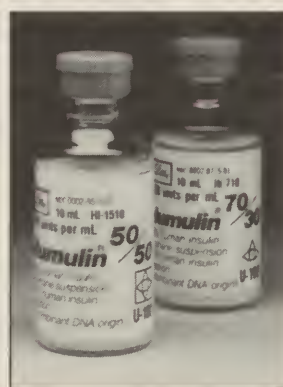
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*The Illinois State Medical Inter-Insurance Exchange met Sept. 11 at the ISMS Conference Complex in Chicago. Following are highlights of the board's actions:*

#### Exchange adopts service initiative

After more than a year of research and planning, the Illinois State Medical Inter-Insurance Exchange Board of Governors unanimously and enthusiastically adopted a comprehensive service plan with specific activities and programs that will strengthen physician malpractice protection, minimize physician frustration with the legal process, reach out to policy-

holders in their local communities to serve them more personally, and encourage speedy and thorough responses to any request. "The board's plan establishes a permanent structure for the Exchange to deliver top quality service," said Harold L. Jensen, M.D., Exchange Board of Governors chairman. (See story, page 9.)

#### Exchange improves physician review mechanisms

As a result of a comprehensive study of the physician review mechanisms to make defend-or-settle decisions and to determine insurability, the Exchange has

approved procedures for improving service to Exchange policyholders undergoing the review process.

A special Exchange study committee was formed to improve two major areas of ISMIE activity: evaluation of new applicants and of existing policyholders' continued insurability, and procedures to determine whether a claim should be defended or settled and what factors should be considered in the decision. The committee recommended streamlining the Physician Review and Evaluation Panels, which make insurability decisions, and the Physician Review Committee, which makes defend-or-settle decisions, along with providing training

for members of both groups. In addition, the role of both committees in improving patient care through education and evaluating risk exposure of ISMIE insureds was more clearly defined.

The committee also called for more communication between PREP and PRC members, and the ISMIS and ISMIE boards. The ISMIE Board of Governors also agreed to annually review PREP and PRC procedures and membership.

Dr. Jensen took the approved recommendations to the ISMIS Board of Directors for implementation.

#### Medication seminar planned

All policyholders will benefit from the Exchange's planned risk management seminar on how to prevent suits arising out of prescribing and administering drugs and medications. The program is planned for spring 1993.

#### Sued physicians can receive support

Policyholders dealing with the stress of being sued can get the support they need by attending the Exchange's Physician Support Group seminars, which are offered quarterly. The most recent seminar was held in Oak Brook on Sept. 9.

The next one is scheduled for the Holiday Inn in Collinsville, Oct. 21. Speakers will include a physician, a defense lawyer and a professional liability analyst who will discuss the Exchange's claims handling strategies. The program is designed to explain what to anticipate with a claim or a suit.

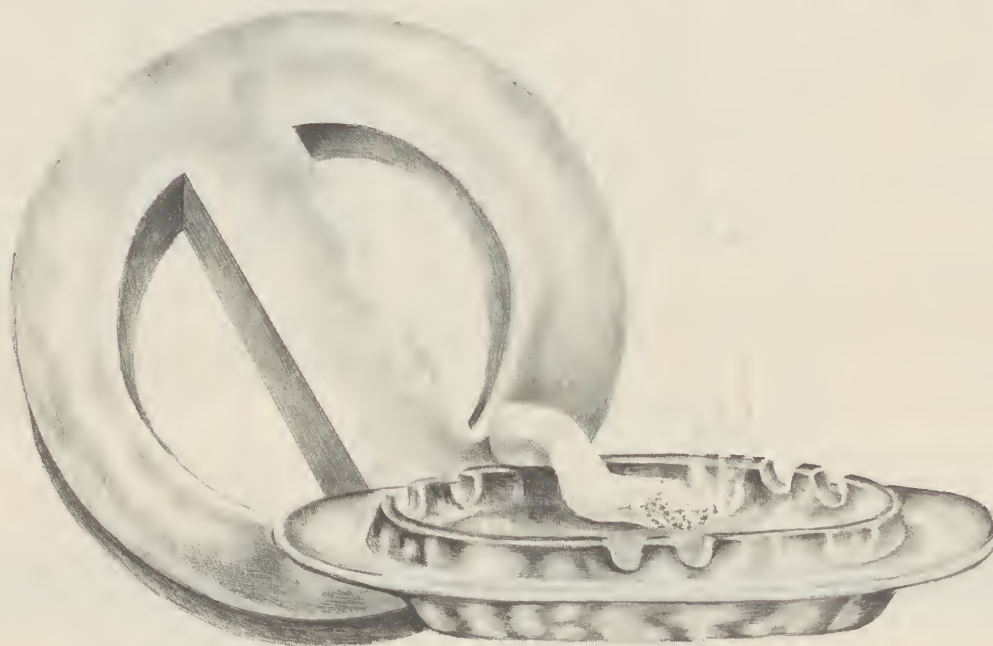
#### Exchange distributes breast implant brochure

Plastic surgeons concerned about media and regulatory attention on silicone-gel breast implants will get the information they need from the Exchange's new brochure, developed by a committee of ISMIE plastic surgeons and defense attorneys. "Exploring Liability Issues - Silicone Gel-Filled Breast Implants" has been distributed to all ISMIE policyholders who perform breast implants.

#### Two specialty risk management subcommittees added

The Exchange's Risk Management Committee, chaired by Jere E. Freidheim, M.D., will form two new subcommittees to study risk management issues in family practice and ophthalmology. Risk management subcommittees have already been formed in obstetrics and gynecology, orthopedics, general surgery, anesthesia, radiology and plastic surgery. ■

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Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654 from 8:30 a.m. to 4:45 p.m. Monday through Friday.

In addition, ISMS President Arvind K. Goyal, M.D., is available for calls the first Wednesday of every month at extension 1333. ■



# AMA reform plan balances public and private concerns

**REFORM:** The AMA's Health Access America reform proposal seeks to insure all Americans through a public-private partnership and expanded Medicaid. By Scott Epstein

[ CHICAGO ] In March 1990, the American Medical Association introduced Health Access America, taking a stand and grabbing attention in the great health care reform debate.

More than two years later, the AMA is refining its proposal to compete for the leadership role alongside business and political heavyweights attempting to make their own voices heard by policymakers.

The AMA says it is working closely with state medical societies, politicians, insurers, employers and special interest groups. In doing so, it expects Health Access America to be front and center when national legislation is ultimately drafted.

The AMA is outspoken in "strenuously resisting" a single-payer health care system, despite the fact that some influential groups favor it. The AMA also rejects the notion of radical system overhaul. Instead, to expand access and contain costs, it offers up a comprehensive private-public partnership approach that builds on the current system's inherent strengths.

At the plan's foundation are the



B.A. FRIEDMAN

AMA's "15 Principles of Health Care Reform" – critical guidelines, according to the AMA, to any national discussion on improving the U.S. health care system.

According to these principles, the health care system must enhance the current employment-based system and help the unemployed. Any

reform legislation should include health insurance market reform – particularly for the small business market – including community rating, elimination of pre-existing condition exclusions, limits on premium increases, portability and continuity.

The AMA says in the perfect health system, all Americans would have access to defined, affordable health care; the freedom to choose their provider; services delivered at an "appropriate cost"; and adequate fee information to make educated choices.

Health care providers would, in turn, deliver high-quality care at appropriate costs and would remain committed to the highest ethical standards. Physicians could negotiate payment and other conditions in government and health entitlement programs while retaining the right

to charge patients their usual fair fee, irrespective of agreements between insurers and patients. It's critical, the AMA insists, that payers don't dictate providers' charges.

The federal government, under the AMA's proposal, would help with and encourage both cost containment and quality, and would financially assist Americans who could not afford insurance. But the government would not serve as the single payer. Centrally controlled regulatory mechanisms, the AMA maintains, would foster government price regulation, inefficiencies and, inevitably, health care rationing.

To attain universal coverage, the plan calls for a federal law mandating employer coverage of all full-time employees, with tax help for all employers, and state risk pools that would aid small businesses and the uninsured. Americans below the federal poverty level would be covered under government programs, such as Medicaid, which would be expanded and targeted to provide uniform, adequate benefits. Health Access America also calls for restructuring Medicare to ensure its own and its beneficiaries' long-term good health.

To control costs, the AMA calls for market-based reforms that provide price information from providers, payment information from insurers, and patient

financial incentives for choosing the type of health insurance and payment method that best meet an individual's needs. It proposes professional liability reform to reduce malpractice insurance premiums and the costs of defensive medicine. To help reduce insurance costs, it seeks to repeal or override the more than 800 state-mandated benefit laws, and to reduce the "excessive and complicated paperwork nightmare" by using a uniform claim form.

The national association says the plan would help ensure the highest quality of care by developing "practice parameters," or patient care strategies (which the AMA, with national specialty societies, is currently developing), so that only appropriate medical services were provided. It urges public and private quality assurance systems and utilization review systems to adopt these parameters.

Specific initiatives require employers and insurers to offer an AMA-drafted "minimum benefits package" in a benefit payment schedule version; a "usual, customary and reasonable" version; and a prepaid version. These options would enable individuals to select their preferred payment method. The AMA's minimum benefits package would cost an employer an estimated \$1,700 a year per employee.

Health Access America will continue to evolve with input from its important audiences and constituents, the AMA says. Their "buy-in," the AMA believes, is critical to seeing the proposal through to legislation. ■

## Reform plans

(Continued from page 1)

approach that, the college says, would keep employers in the system by moving the most expensive costs, catastrophic coverage and coverage for employees over the age of 60 into the public system. Income-related premiums for retirees, unemployed people with incomes above the poverty level and employees over the age of 60 in companies that provide insurance are also part of the plan that is sure to generate controversy. Insurance reform is included, but the college avoided enumerating a "basic services" package found in many other proposals. Instead the plan would cover "all medically effective and appropriate care." Utilization and quality review would be the responsibility of hospitals, organized delivery systems and professional organizations, rather than insurers, PROs and proprietary groups.

When it was introduced in late September, the plan was endorsed by the American Association of Retired Persons, the powerful senior citizens lobby, and by Chrysler Corp.

The American Society of Internal Medicine has also published a proposal for reform that, it claims, addresses everything from increased access to reduced administrative hassles.

A major feature of the ASIM plan is the creation of a system that allows patients, benefits purchasers and physicians to compare physicians' charges and insurance payment rates. The system would require all parties to begin the pricing process with the RBRVS rates; then insurers and physicians would select their own dollar conversion rates,

which would, by law, be public information. Patients would be able to project physicians' fees and compare them to projected insurance payments. This "informed consumer" approach would have an immediate effect on health care expenses, the society claims.

The ASIM plan includes the "pay or play" feature many reform proposals include: Employers either provide health insurance coverage as a benefit ("play") or contribute to a government-funded insurance program ("pay"). Critics of this option contend that unless the employer tax assessed to fund public programs is set high enough, employers will be encouraged to "dump" employees into the public program as a cost-savings measure; as a result, critics say, the system will inevitably erode into a single-payer, government-run system.

The American Hospital Association bases its plan on a concept it calls "health networks," a coalition of community provider groups providing comprehensive patient care for an annual fee. The program – which would be hospital-based, if not hospital-owned – raises the specter of physician employment by hospitals, which may have been one reason it was defeated by the AMA House of Delegates at its annual meeting in June. In the Aug. 20 issue of the AHA publication *Hospitals*, George Belsey, AHA executive vice president, defended the proposal, saying, "Community care networks can enhance physician autonomy by returning to them the responsibility of caring for patients and eliminating them from the external micromanagement of insurers and the government."

The program would also restrict patient freedom of choice, AHA officials

admit. Calling the current system "fragmented and uncoordinated," the hospital association also called for tort reform and antitrust and small-market insurance reform measures.

Just over a year ago the American Academy of Pediatrics endorsed a bill in Congress containing a reform plan targeting the needs of children and pregnant women. Based on the AAP's "Children First" access plan, the Children and Pregnant Women's Health Insurance Act of 1991 would guarantee access to comprehensive health care for all children through age 21 and for pregnant women. Another "pay or play" proposal, the bill calls for employer-provided health care benefits and a public program.

Coverage would include uniform health benefits, regardless of income; full coverage of preventive care, including immunizations; and mandated benefits for employees' dependents and pregnant employees.

The American Psychiatric Association, the National PTA, the Child Welfare League and other child advocacy groups supported the AAP proposal when it was introduced by lead sponsor U.S. Rep. Robert Matsui (D-Calif.)

The American Academy of Family Physicians' proposal for reform hinges on increasing the number of primary care physicians to 50 percent of the total physician population. Other elements of the plan include free prenatal and childhood immunization screenings for all, and national, uniform limits on deductibles, coinsurance and out-of-pocket contributions. A Medicaid basic health services package would include prenatal and maternity care, infant care, dental care, treatment and rehabilitation

of injury, diagnosis and treatment of illness and dysfunction, care of elderly people and terminal care.

All patients would be assigned to a personal physician who would be a family physician, general internist, general practitioner or general pediatrician; this doctor would serve as a gatekeeper to control the use of specialized services. Patients who self-refer to specialists for nonemergency conditions would pay higher deductibles and copayments.

The AAFP estimated gross costs to employers, who would be required to pay 75 percent of the cost of employees' health insurance, would be \$26.8 billion; under its proposal, 83 percent of those now uninsured would be covered by the plan.

In Illinois, the Illinois Nurses Association has testified repeatedly in support of the universal health care proposal considered in the General Assembly in the last session. Key to the nurses' support of the program, according to an INA spokesperson, are guaranteed universal access and the provision of comprehensive coverage, as opposed to the basic package of health care services many other proposals include. The Illinois Hospital Association, on the other hand, has joined with ISMS and the state's health insurance industry in lobbying against the single-payer, government-run system proposed by consumer groups.

ISMS has adopted 10 principles by which reform proposals can be evaluated, and its Third Party Payment Processes Committee is studying ways to positively impact legislation concerning health care reform. ■



# Twelve key Illinois House races in election spotlight



*Illinois Medicine* continues its 1992 pre-election coverage by focusing on Illinois House of Representatives races in selected suburban Cook County and northern Illinois districts. Of the 12 contests profiled, redistricting resulted in two incumbents' running against each other. Eight other races feature an incumbent – including Rep. David K. Deets, M.D., the only physician currently in the General Assembly – trying to retain a seat in a newly drawn district. Profiles of key races in central and south central Illinois will appear in the next issue.

35  
th  
DISTRICT



## Jane M. Barnes (I) – Republican

Two longtime incumbent representatives are facing each other in a newly drawn 35th House District. Rep. Jane M. Barnes, who has represented the 38th House District since 1975, is running against Rep. Terry A. Steczo. Barnes, of Palos Park, provided the following statement to *Illinois Medicine*:

“While there has been a great deal of attention placed upon other countries, especially Canada, where the government essentially runs the health care system, Americans are not accustomed to the many problems this system has created in Canada. As in other countries, this will likely mean a decrease in access to services; lack of choice for consumers on where to receive treatment; limited availability of technology to control costs; queuing and waiting lists, even in life-and-death situations; and reductions in the research and development of new life- and pain-saving medical technologies.

“Access to health insurance must be improved, and the rising costs of health care must be curbed. These problems, however, are interrelated, and so it is not always clear which is the cause and which is the effect. For example, controlling the cost of health care should improve accessibility and reduce the number of uninsured individuals. Fewer uninsured individuals means less uncompensated care. Decreasing the amount of uncompensated care reduces the costs that health care providers must pass on to paying customers or, in other words, helps to control the cost of health care.

## Terry A. Steczo (I) – Democrat

Terry A. Steczo, of Country Club Hills, has represented the current 78th House District since 1977.

Steczko does not believe that a single-payer, government-run health care delivery system is fiscally viable. “It became obvious to us [during last session’s debate on the universal health care bill] that Illinois simply cannot afford to do something like that.”

Although Steczo opposes a single-payer system, he does call on the federal government to take the lead in health care reform because the “state doesn’t have a printing press in the basement to pay the initial costs associated with any kind of reform. ... It’s obvious that [it’s better to have] a national policy than having each state do something different from the state next door.”

Steczko believes that tort reform, especially strengthening provisions to discourage frivolous suits, must be a component of any health care reform initiative. He has opposed caps in the past because he has not seen enough evidence that they effectively control health care costs. “One of the reasons we vote against a lot of things is that you need substantiation. You simply cannot be in a position of believing everybody who tells you anything.”

36  
th  
DISTRICT



## Maureen Murphy – Republican

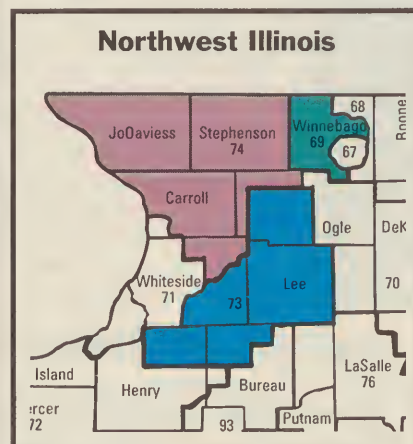
Maureen Murphy, of Evergreen Park, is challenging longtime 29th House District incumbent Andrew J. McGann in the new 36th House District. The mother of four children, Murphy is a 10-year member and vice president of the Evergreen Park High School District 231 board. She served as Worth Township clerk from 1985-89 and has been active in raising awareness of the need for increased fund-

ing of breast cancer research.

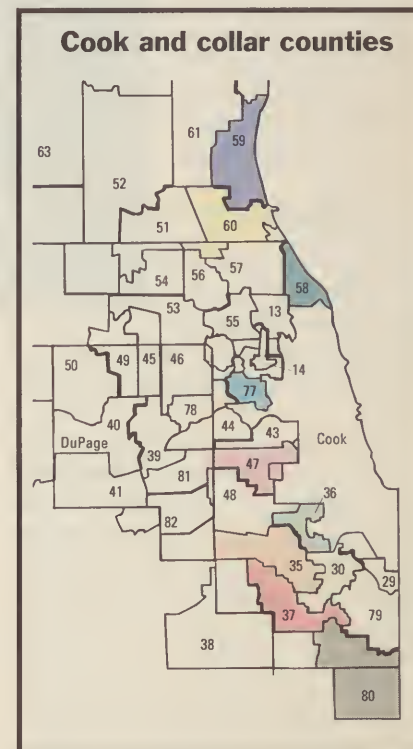
Murphy opposes a single-payer, government-run health care delivery system. She said the federal government should take the lead in establishing national health care policy, and should also “be coming up with some of the dollars. We have to recognize that states [have] rights; there are certain geographical [factors] that call for regionalization. I recognize it’s a partnership ... [but] the federal government has to lead the way.”

Murphy favors standardizing claim forms in both the private and public sectors as a major first step in containing health care costs. She is also a “real proponent of prevention,” she said.

## Selected Illinois House Districts



Source: Illinois State Board of Elections



36  
th

DISTRICT



## Andrew J. McGann (I) – Democrat

Rep. Andrew J. McGann has represented the current 29th House District since 1983. He is running for re-election in the newly drawn 36th District.

“Health care reform needs to be both a state and national level priority,” McGann said. “We must realize Illinois cannot financially fund a health care system in this state alone. The funds must come from federal levels in order to provide every citizen

with health care.”

McGann called for more federal help in paying Medicaid claims. “Each state must be far more responsible in paying its bills owed to doctors, hospitals and all other medical care providers. If the federal government assumed some of the responsibility of funding health care [on] the state level, the state would then be able to pay bills promptly.”

McGann opposes the Canadian-model single-payer, government-run system, preferring to adapt systems from other states to Illinois’ needs. “I do not believe the Canadian plan is the best answer for health care reform. We should look to other states like Minnesota and Oregon, which [developed] health care systems based on their state needs, and use them as guides for finding a solution that can work in Illinois. Again, I believe the federal government should take more responsibility for funding health care.”

McGann favors a cap on noneconomic damages but said \$250,000 is too high. “A comprehensive solution to the [malpractice problem] should be found with all parties involved, [including] government, doctors, hospitals, large drug companies, small pharmacies, nursing homes, business, labor, the legal community and the insurance industry.”

**Illinois Medicine will cover additional key races for the House of Representatives in the Oct. 23, 1992 issue.**



37  
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DISTRICT**Carl James Vandenberg – Republican**

Carl James Vandenberg has been a Tinley Park village trustee for nine years. An attorney specializing in real estate development, he and his family owned several small businesses, including an ambulance company and a medical supplies store. He and his father have owned a funeral business for several

years.

Vandenberg opposes a single-payer, government-run health care delivery system. "I believe that governmental involvement in health care is not the solution for a better level of service or more efficient, less-costly service," said Vandenberg. Instead, he favors insurance industry reforms to broaden risk pools and to permit "portable" health insurance for employees who change jobs. "In addition, the state has to stop mandating additional programs that clearly increase the cost of services and make it more expensive for all coverages," he said. "We [also] need to look at and expand more restrictive coverages so that people can afford some form of health coverage."

Before tackling Medicaid reform, Vandenberg would wait to see the recommendations of the panel that was created in the wake of the hospital assessment program. He favors caps on noneconomic damages but has not yet decided on a figure.

**John R. Sheehy – Democrat**

John R. Sheehy of Tinley Park is a third-generation funeral director and co-owner of a business that has been family-owned since 1910. Mr. Sheehy provided the following statement:

"I believe that health care costs have risen out of the reach of the citizens of Illinois. Costs for insurance coverage prevent a large segment of our society from receiving health care benefits. Employers have

reduced or dropped employee health programs entirely. Hospital emergency rooms are overextended by uninsured trauma patients and patients without primary care physicians. The state and federal government have reduced benefits and funding.

"I feel strongly that the health care crisis must be addressed and that these and other related issues must be resolved. We need to provide accessible and affordable health care coverage for the citizens of Illinois. The federal government must meet its responsibility to fund and administer effectively its programs. The state must also meet its responsibility by working with the federal government and balancing its own budget. In addition, we must all work together as doctors, lawyers, businesspersons and government officials at addressing our tort system. The health care crisis will be a top priority for me as a state representative."

**James R. Donoval – Republican**

James R. Donoval is running for a seat in the Illinois House in the new 47th District. He furnished the following statement on his health care positions to *Illinois Medicine*.

"I do not believe a national or state-run health care system is the answer to our health care problems. Such a system would cause both a serious decline in the quality of care and dramatic increases in waiting

time for services.

"We need to provide a government-backed health care insurance program for people who do not have health care insurance due to pre-existing conditions, who work part-time or are otherwise not covered by employer-paid plans, and who are self-employed and cannot afford such coverage. This program should be reasonably priced and should allow access to all people who do not currently have insurance.

"As a society, we already request certain types of insurance (auto and Social Security) so I find it no tremendous burden on individuals that we require health insurance, so long as it is affordably based on a person's income. When people do not have insurance, all taxpayers end up paying their medical costs in the long run.

"I also believe we should place moderate limitations on our health care insurance industry, and I believe we need to modify our legal system, as well. Our health care system suffers because of the need for physicians to practice defensive medicine. We all agree that anyone, including doctors, must be responsible for negligent or purposeful injuries. But we must stop blaming doctors and other health care providers for bad results. I support a much stricter program of arbitration and review of claims for damages even before suits enter the court system. And we must restrict damages awarded for noneconomic losses, awards that have no objective method of valuation."

47  
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DISTRICT**David B. McAfee (I) – Democrat**

David B. McAfee, of Indian Head Park, is a one-term representative of the 47th House District.

McAfee noted that when he took office two years ago, his first legislative hearing was on health care. "I suspect when [people] ran for election two years ago, no one thought that it would reach this level of concern. [Health care reform] is national level and it's crisis level."

McAfee opposes a single-payer, government-run health care system. "Two years ago when ISMS asked me if I favor a Canadian-type system, my answer was no, and it's no now. I don't know that our experience on a federal level with Medicare has been all that good."

McAfee said that whatever plan is implemented should be uniform across the 50 states. He remains open, however, to a specific proposal. "I think they'll have to work their way through it at the congressional level to put together the plan that would suit our country the best and try to cover those people who are not getting the care they need."

He favors tort reform, but does not support caps on noneconomic damages "much like I prefer not to have caps on medical providers' costs; nor do I want to make it a no-fault system like workers' compensation." McAfee would, however, establish a three-member panel to review potential suits. The panel would include a physician, preferably a specialist in the area of the complaint. If the panel deemed the suit frivolous, the suit could proceed, but losing plaintiffs would be liable for all costs and fees. "It may not be the whole answer," McAfee said, "but we have to do something to stop the frivolous lawsuits."

58  
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DISTRICT**Jim Henderson – Republican**

Born and raised in what's now the new 58th legislative district, James Henderson, Republican candidate for the House seat, is a vice president at Smith Barney, an investment firm in Chicago. He rejects the concept of a single-payer, government-run system modeled on the Canadian health care program. Instead, he supports the establishment of reinsurance

pools to cover catastrophic (in excess of \$25,000) health care expenditures for privately insured patients. He also supports the standardization of claims forms and UR methods.

To increase access, Henderson would provide vouchers or tax credits for people unable to afford health care insurance, and he would eliminate state-mandated benefits in an effort to control increases in health insurance premiums.

Neither the "pay or play" system nor an expansion of Medicaid to cover more people wins Henderson's approval, although he is on record as supporting a \$250,000 cap on noneconomic damages and a requirement that the loser of a case must pay the other side's court costs and attorney's fees.

On related topics, Henderson said he would support the independent practice of nurse practitioners that would allow them to diagnose and treat disease and to prescribe drugs "only with the appropriate and professional regulation of (their) practice."

**Jeff Schoenberg (I) – Democrat**

Schoenberg, finishing his first term in the House, served on the House Health Care Committee; he believes any long-term solution to the health care crisis must be discussed at state and federal levels.

"If Illinois were the only state in the region offering the Russo plan, for instance, it's conceivable that people from Wisconsin and other states would establish residency to receive medical services,"

Schoenberg said.

Schoenberg told *Illinois Medicine* he believes in universal access but does not support a single-payer, state-run system. "The ultimate solution to the wide disparity in access to health care services in Illinois must come through a combination of public and private services. Certainly the Canadian system is not the answer," he said. "There are conflicting reports as to how much administrative savings would actually be generated as a result of a state government-run system." Under a state-run system, Schoenberg said, Illinois could "find itself with an even greater budget deficit than we already have.

"I am most inclined to support a German 'pay or play' program, or some version of it," he said.

"[Part of the problem is] the increasing number of Federal mandates in the Medicaid system, which have had a financially devastating effect on health care in Illinois. The federal government hasn't provided the states with a means for covering these people."

Schoenberg says he is undecided on tort reform. "Professional liability is just one of many variables contributing to rising health care costs, from increased Medicaid mandates to the costs of technology. Any health care reform legislation that is passed will have to address all the variables."

47  
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DISTRICT



59  
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DISTRICT**Virginia Fiester Frederick – Republican**

Rep. Virginia Fiester Frederick, of Lake Forest, has been a member of the Illinois House of Representatives for 14 years and currently serves as assistant minority leader of the House. She is a newly appointed member of the House Health Care Committee and also serves on the Revenue, Aging and Education Finance committees. She voted for the

AIDS notification bill and against the universal health proposal. In 1992 she served as a co-sponsor of the fibrocystic breast disease bill signed by Edgar Sept. 13.

"In order to achieve coordination of health care between the states, any health care reform is going to have to be a federal program," she told *Illinois Medicine*. "A mix of private and public coverage for medical care will probably be the way to go."

Frederick has studied the Canadian health system, and is concerned about the funding level necessary to implement a single-payer plan. "While it's true that medical care is 'free' in Canada, I've just found out that massive sales taxes are being implemented in Canada to fund health care. Just watching what has happened with the decline in educational funding in Illinois makes me uncertain that the state can adequately fund a single-payer system in Illinois," she said.

Responding to the question of how the state could address problems in Medicare and Medicaid, Frederick said the funding levels for these programs need to be increased.

Asked about caps on malpractice awards, Frederick said, "Malpractice impacts all consumers of health care services, and these unnecessary awards are driving the health care cost crisis. I believe that people who are really injured through malpractice should be reimbursed and should be cared for, if necessary, for the rest of their lives. But we can cap noneconomic awards, for example, and help control our health care costs."

**John S. Matijevich – Democrat**

Mr. Matijevich did not respond to repeated requests for an interview.

**Charles A. Cardella – Republican**

Charles A. Cardella, a small-business owner from Buffalo Grove, "knows what it's like to make a payroll" and would bring a business perspective to the Illinois House, he said.

Firmly against a single-payer national health plan, Cardella advocates corporate incentives, including tax deductions for providing health insurance.

"There has got to be reform, and it has got to be private," he said, explaining that reform is needed at both the state and national levels. "When the government gets involved, we get higher taxes and more bureaucrats."

"We need to give health care providers incentives to do *pro bono* work, and we need to give them a reason to do it," Cardella added. "We need more people in the private sector getting involved."

To curb the Medicare and Medicaid crisis, he said he opposes ever-increasing taxes and prefers a government matching program.

"My belief is that we need more money in the economy, that it must be expanded and invigorated. Revenues have to be found," he said.

Cardella supports capping punitive damages in malpractice awards and federal legislation to curtail the number of appeals allowed.

**Lauren Beth Gash – Democrat**

Lauren Beth Gash, an aide to state Rep. Grace Mary Stern (D-Highland Park), is a 1987 graduate of Georgetown University Law Center in Washington, D.C. She has served as a field representative in the Lake County Clerk's office, and was 94th Precinct committeewoman and member of the Lake County Democratic Central Committee. She also served on the League of Women Voters' Health Care Study

Committee.

"American families are unduly burdened by rising health care costs, and U.S. businesses are at a competitive disadvantage internationally," Gash said. "Until the federal government can devise policies to guarantee universal access to health care to control skyrocketing costs, states will continue to face funding crises."

"In theory, I support a type of universal system of health care that would guarantee universal access," she continued. "I have serious concerns about funding sources, which is why I am not endorsing any specific proposal at this time." Gash said she believes a universal health insurance plan would most effectively cut costs but she is still uncertain as to whether caps on malpractice awards would help curb costs. She said alternative measures need to be explored.

69  
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DISTRICT**David Winters – Republican**

David Winters, of Shirland, a farmer for 16 years, has been a member of the Winnebago County Board for six years. He was educated at Dartmouth College and the University of Illinois.

Opposed to a single-payer, government-run system, Winters said he thinks that "competition in the free market will lead to the most efficient use of [health care] resources."

Winter cited three things the state can do to reform its health care delivery system. "We can look at using additional incentives to modify behavior, [particularly] incentives to the public aid people to choose health care wisely. That may be in the form of an incentive to get prenatal care or other preventive care so that they come in before the illness gets to the serious, 'emergency room' state. I think we can save a lot of money that way."

"A second approach would be to try to simplify the number and style of forms that the insurance industry is using," Winters continued. "And a third would be in the area of tort reform. That would help hold down malpractice insurance, which obviously then will be reflected in a lower cost of operation for the medical industry." Winters favors caps on noneconomic damages but has not decided on a figure.

Winters also called on the federal government to give the states more flexibility in administering federally mandated programs.

**Michael V. Rotello (I) – Democrat**

Michael V. Rotello is a first-term House member representing the current 67th House District. He is running for re-election in the new 69th House District. Rotello provided the following written statement:

"I believe a consensus must be reached between government and health care providers to end the ever-increasing costs associated with basic health care. The federal government is where most of these efforts should be concentrated to create a 'market of scale.' However, if the federal government is unwilling to act on this issue, the state must be prepared to act. If we get to that point, we must consider all options presented. A market-based plan is preferable; however, I am open to all options on this question."

"More funding must be secured from the federal government to operate [Medicare and Medicaid in Illinois]. Unfortunately, the 'New Federalism' of the 1980s passed this mandate down to the states, with the result of nearly bankrupting some states. Any costs which the states must pay for Medicare/Medicaid should be derived from general revenue funds, as opposed to an unfair hospital/nursing home assessment plan, which only taxes those who happen to get sick or grow old."

"At this time, I have not yet seen a proposal for medical malpractice caps that I can support. I am, however, acutely aware of the need to hold costs down for providers of medical services. I am very willing to consider options such as alternative dispute mechanisms or other compromise solutions."

73  
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DISTRICT**David K. Deets, M.D. (I) – Republican**

Rep. David K. Deets, M.D., the only physician currently serving in the General Assembly, is waging his first election campaign in the new 73rd House District. He was appointed to his 70th House District seat in March 1992 to complete the unexpired term of Rep. Myron J. Olson (R-Dixon), who died in January.

"The 'universal health care' plan would just be impossible for Illinois or any other state to fund," Dr. Deets said. "Last year, the proposed price tag for 1993 or 1994 was \$54 billion. If you divide that amount of money by every person in Illinois, it comes out to \$4,900 per person. For a family of four, it would cost about \$20,000. So, that would be an outrageously expensive proposal for any state to undertake."

Dr. Deets favors reforms in the insurance industry, including coverage of pre-existing conditions; community rating instead of experience rating; and small business risk pools. "And, in tort reform, we have to look at capping noneconomic losses, in particular, and also developing some kind of claims adjudication that could be done less formally than in a courtroom," said the general surgeon from Dixon.

"For the people who truly can't get insurance because of their economic status, [we should] expand the Medicaid program, which will be expensive," said Dr. Deets. "But I think those expenses can be kept in line with primary care physicians who would accept Medicaid patients, acting as gatekeepers, just as they do in an HMO."

Dr. Deets also had some political advice for his physician colleagues. "I think physicians have to study the issues extremely carefully," he said,



encouraging physicians to participate in the debate. "They can't approach it in a defensive manner. ... For physicians to represent their own interests, they have to become involved and understand the implications of these programs. They just can't get up and say, for instance, 'The Canadian system doesn't work [because] people have long waiting lines,' and so forth, and so on. They have to look into it deeper than that. Physicians, from my experience, tend to be very reactive, not proactive. They need to look at the issues and not just take off on something."

### **Pennie L. von Bergen Wessels – Democrat**

Pennie L. von Bergen Wessels declined to be interviewed for this article, saying that she and her opponent were scheduled to address the White-side County Medical Society on Sept. 24.



### **I. Ronald Lawfer – Republican**

I. Ronald Lawfer, a dairy farmer from Stockton, was an Orange Grove township supervisor for eight years and for 10 years has served on the Jo Daviess County Board. He currently serves as a commissioner of the Illinois Rural Bond Bank, which helps finance infrastructure for rural communities.

Lawfer opposes a single-payer, government-run health care delivery system, saying, "I am in favor of less government, not more."

To help control Medicaid costs, Lawfer would streamline the administrative process. "I think the biggest cost saving would be reduction in the paperwork," he said. "Rural nursing homes in my area say their staff people spend 40 percent to 50 percent of their time on paperwork. And the director of nursing of a small 70-bed nursing home does not have any time for supervision."

Lawfer said that federal mandates to the states need to be modified, but any health care reform must be uniform among the states. He favors more emphasis on preventive medicine and some insurance industry reforms. He said individuals should take more responsibility for their health care, including assuming partial payments for their premiums and benefits.

Lawfer also favors caps on noneconomic damages but said a \$250,000 cap "sounds high to me; I wonder if a hundred thousand isn't more realistic." He said individuals who file frivolous suits should be liable for court costs and attorneys' fees.

### **Richard T. "Dick" Mulcahey (I) – Democrat**

Richard T. "Dick" Mulcahey, of Durand, has represented the 69th House District since 1975. He did not return calls requesting an interview, nor did he provide a written statement on his views.



### **Angelo "Skip" Saviano – Republican**

The supervisor of Leyden Township since 1989, Angelo "Skip" Saviano is a 1980 graduate of DePaul University. He has served on the West Cook County Solid Waste Agency Executive Board, the Northwest Youth Outreach Program and the Cook County Township Supervisor's Association. He owned and operated a paralegal service in Chicago for eight years.

Saviano said that federal and state government should work together to coordinate health care reform but that the federal government should play the most prominent role, since it is "totally responsible for Medicare and mostly responsible for Medicaid."

He called a single-payer national health system "extraordinarily costly," saying that it would more than double the state budget, "requiring massive tax increases and placing a tremendous burden on our economy." Saviano favors several Republican-sponsored bills pending in the U.S. Congress that would "reform the system based on a competitive model."

He advocates greater focus on managed care, health education and preventive care, and said, "Every person on Medicaid ought to have a primary care physician."

On tort reform, Saviano said a system should be implemented through which the loser in a court case must pay the winner's attorney's fees and court costs.

### **Geoffrey S. Obrzut (I) – Democrat**

Rep. Geoffrey S. Obrzut, who has served as representative from the 52nd District since last year, declined to comment.

## **80th DISTRICT**

### **Robert P. Regan (I) – Republican**

Rep. Robert P. Regan, of Richton Park, has represented the 80th District since 1985. An insurance broker with his own agency, Rep. Regan has served on the Committee on Children and Family Law, the Committee on Insurance and the Committee on Health Care, for which he was vice spokesman. He attended Thornton Junior College and Wesleyan University, and is a former vice chairman of the Will County Board.

Rep. Regan believes that imposing caps, particularly on punitive damages, is one of the best ways to reform the health care system. "The deep-pocket approach to the tort law system is bankrupting our country," he told *Illinois Medicine*.

Rep. Regan supports health care reform at the national level. He said a state universal health plan would require senior citizens to drop coverage for Medicare and would require the disabled to drop Social Security disability payments. "I don't believe anyone wants to do that, considering Illinois' financial problems," he said.

He does not favor a single-payer, government-run health care system and instead advocates cost containment in the current system. "We're moving in the right direction," he said, explaining that hospitals can cut costs by sharing certain equipment, such as MRI scanners.

"We need to get tort law straightened out. That way doctors won't have to do as many tests," he said.

### **John A. Ostenburg – Democrat**

John A. Ostenburg did not respond to several requests for an interview. ■

## **If you don't vote ...**

**On Tuesday, Nov. 3, a new U.S. president, a new senator and a new Illinois General Assembly will be elected. Only those registered voters who go to the polls will decide those races. If you don't vote, you can't complain about the results. Make the time to make a difference ... VOTE.**

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## **74th DISTRICT**

## **77th DISTRICT**



## EDUCATION

# Breaking the chain of family violence

*Organized medicine takes the lead in educating physicians about the telltale signs of child and spousal abuse.*

BY RACHEL BROWN

**I**t's a frightening epidemic. Statistics show that every year more than 130,000 children and between 200,000 and 300,000 women in Illinois are beaten, abused and sometimes killed in their own homes. Although domestic violence strikes one in four families, victims are often afraid to talk about their problem and don't know where to turn for help.

Because physicians see many of these victims in various health care settings, they are in a unique position to help combat this growing problem. Encouraging them to do just that is the focus of family violence programs initiated by the American Medical Association and the Illinois State Medical Society Auxiliary.

The AMA, through its Campaign Against Family Violence, has developed guidelines to help physicians look beyond physical symptoms, ask the right questions, and identify and treat the victims of physical and sexual abuse. At the grass roots level, the ISMS Auxiliary is working to help victims emotionally and financially.

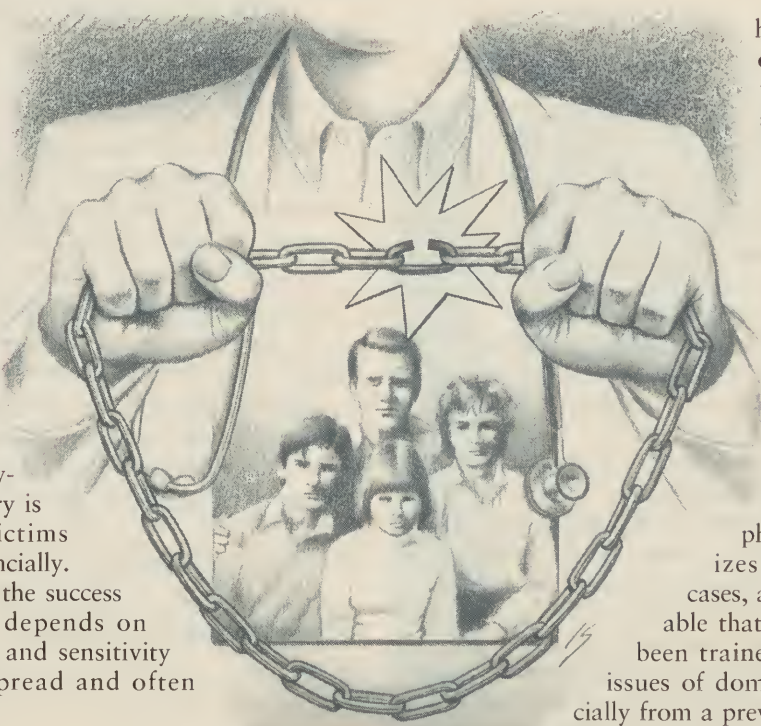
Experts agree that the success of both programs depends on acknowledgment of and sensitivity toward this widespread and often unreported problem.

**DOMESTIC VIOLENCE, A PATTERN** of control and domination, can affect both sexes, although women are most often the victims. Experts agree that domestic violence is often not properly diagnosed because physicians have not been trained to recognize it.

The AMA reports that abused women account for 22 percent to 35 percent of women seeking any type of medical care in the emergency room, although only 5 percent of those are identified as domestic violence victims. In addition, of the more than 25,000 women who received help last year from the Illinois Coalition Against Family Violence, only 3.6 percent were referred by physicians and hospitals.

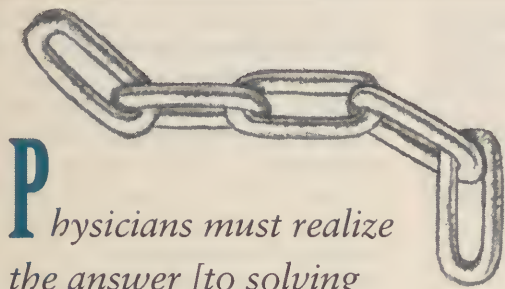
"Physicians treat headaches, pain and other physical symptoms of living in stressful, abusive relationships, but the underlying problem isn't addressed," said Carole Warshaw, M.D., a member of the committee that developed the AMA's domestic violence guidelines.

Anthony H. Dekker, D.O., a Chicago family physician who specializes in family violence cases, agreed. "It is inexcusable that physicians have not been trained well to deal with issues of domestic violence, especially from a preventive or early inter-





## E D U C A T I O N



**P**hysicians must realize the answer [to solving the family violence crisis] is working in concert with all these other disciplines with the common goal of a healthier life."

— Anthony H. Dekker, D.O.

a relationship where your partner ridiculed you continuously or threatened you? Do you ever feel afraid of your partner? What happens when you fight? Does it get physical?"

Trust, privacy and confidentiality are especially important when questioning children about abuse, Dr. Dekker stressed. He recommended that physicians ask questions such as, "How are you disciplined at home?" or "Are there any things going on at home that really make you upset?"

Under Illinois law, physicians are required to inform the Department of Children and Family Services if child abuse is suspected. It is important, Dr. Dekker added, for physicians to realize their limitations and offer support from local resources such as social workers and psychologists.

"Physicians must realize the answer [to solving the family violence crisis] is working in concert with all these other disciplines with the common goal of a healthier life [for victims]," Dr. Dekker said.

Spousal abuse victims also need to know they have their physician's respect and support, even if they decide not to leave an abusive relationship immediately, said Hollenkamp.

Hollenkamp, who has worked at the crisis center for eight years, cited several reasons abuse victims return to violent relationships. Often fear, embarrassment, emotional and financial dependence, or threats make it more dangerous for women to leave than to stay, she said.

Dr. Warshaw, who is also director of the behavioral science and primary care residency program at Cook County Hospital in Chicago, pointed out that abused women often deny the abuse, defend their partners' actions or blame themselves. Society's traditional attitudes toward women and marriage can exacerbate the problem.

"Many of these women believe that what [they] do is wrong and it is [their] responsibility as the wife to make the marriage work," she said.

In these instances, such simple actions as displaying posters, making referral sheets available in the office and informing the victim that she doesn't deserve the abuse will prove the physician's concern and interest in the patient's safety, Hollenkamp added.

**HOW DOES FAMILY VIOLENCE** begin? Specialists agree that domestic violence crosses all economic, racial, ethnic and age lines, although there are certain risk factors that increase its probability.

Dr. Dekker warned physicians to be especially aware of the increase in drug and alcohol abuse and of the fact

vention standpoint."

Developing a strong relationship with patients is the first step in diagnosing and treating the problem, experts believe. Physicians should not be afraid to question their patients directly about abuse, provided the questions are asked in a caring, compassionate and nonjudgmental way, said Mary Hollenkamp, R.N., a volunteer nurse at the Women's Crisis Center in Belleville.

Dr. Warshaw suggested asking spouses, "Have you ever been in

that "chemical use and family violence go hand in hand."

Physicians should also be on the lookout for families experiencing high levels of stress or economic problems.

"Physical abuse and neglect are precipitated by stress," said Stephen H. Sheldon, D.O., chairman of the 1987 ISMS ad hoc committee on child abuse education. "As the recession and unemployment increase, stress increases, as well as abuse."

In the case of child abuse, the AMA guidelines tell physicians to be especially sensitive to families in which other home violence is occurring, for example if the father abuses the mother, or siblings abuse one another.

"Even if a child has never been struck, the fact that someone is being victimized in the home is emotionally traumatic," explained Dr. Dekker.

In addition, Dr. Dekker pointed out that unsupervised or inadequately supervised children are at a higher risk for domestic violence. "Absent parent[s] cannot protect their child," he added.

To address such situations, the Vermilion County Medical Society Auxiliary established a unique child abuse prevention program five years ago.

The program focuses on educating elementary school children about "body safety issues, gives [them] an avenue to talk about sexual abuse and makes [them] less vulnerable to it," said auxiliary member Darlene Halloran, who initiated the program.

To begin the program, the auxiliary purchased curriculum guides and paid for training teachers and principals to deal with child abuse. The program focuses on teaching young children survival skills and making wise decisions when home alone. Because of the program's success, additional substance and child abuse programs have been developed, said Halloran.

In Illinois, several other county medical society auxiliaries have taken steps to tackle the family violence problem in their areas. The St. Clair County Medical Society Auxiliary has held several fund-raising golf tournaments to purchase medical equipment and stock medicine cabinets for the Belleville Women's Crisis Center, said Mary Kappel, county auxiliary president.

According to Kappel, the auxiliary raised \$8,900 last year for the center, which offers residence, counseling, and crisis intervention for up to 28 abused women and their children in a three-county area.

Last March, the Coles-Cumberland County Medical Society Auxiliary co-sponsored its first household items and clothing drive for a crisis center in Charleston serving women from five surrounding counties.

The drive was organized after the AMA Auxiliary initiated its campaign and encour-

(Continued on page 20)



## Firearms safety begins at home

Home violence is a growing concern in the United States, and firearms play a leading role in this problem. According to the National Safety Council, 13,600 homicides are caused by these weapons each year, 800 of them in the home. With proper safety precautions, however, many firearm deaths could be prevented.

Gun owners should equip firearms with trigger locks and/or keep them unloaded and locked up. All ammunition should be locked up, away from guns and sources of heat and electricity.

Because more than 1,400 deaths annually result from accidental shootings, guns should always be carefully checked to make sure they are unloaded before further handling. In addition, when handling a firearm, the muzzle should always be pointed in a safe direction and horseplay should be forbidden.

It is also important to keep firearms inaccessible to children and to teach all youngsters about gun safety. The National Safety Council reports that each year 250 firearm deaths involve children under age 14.



## Guidelines for physicians on handling family violence

### Child physical abuse

Commonly associated with abuse are certain types of injuries – those that are not explained by the history, are located on multiple body sites or are in various stages of healing. The medical recognition of abuse, however, may be based on a single injury.

*Physical findings that may indicate physical abuse are:*

- Bruises and welts forming regular patterns, often resembling the shape of an

article used to inflict the injury;

- Burns (cigar or cigarette burns, especially on the soles, palms, back or buttocks);
- Immersion burns; and
- Lacerations or abrasions to the palate, mouth, gums, lips, eyes, ears or external genitalia; or rope burns, particularly on the wrist, ankles, neck or torso.

*Behavioral findings of abuse include:*

- Impaired interpersonal relations;
- Role reversal; and

- Excessive household responsibilities, including child care.

### Child sexual abuse

*When interviewing a child, a physician should:*

- Sit near the child, not across a desk, and sit at the child's eye level;
- Conduct the interview in private, without the caretaker present;
- Find out who else has questioned the child; and
- Use the child's own words and terms

whenever possible in your notes.

*Do not:*

- Suggest answers;
- Leave the child unattended or with unknown persons; or
- Offer rewards to the child.

*When interviewing caretakers:*

- Reserve judgment;
- Attempt to be objective; and
- Explain further actions that will be required.

*Do not:*

- Attempt to prove abuse;
- Pry into unrelated family matters; or
- Give feedback on the caretaker's explanation of how the injury occurred.

### Spouse abuse

Once abuse is identified, a number of interventions are possible. Even if a woman is not ready to leave the relationship or take other action, the physician's recognition of her situation is important. Optimal care also depends on the physician's knowledge of community resources that can provide safety, advocacy and support. Thorough medical records are essential for preventing further abuse and may prove crucial in a legal case.

*Records should include:*

- The chief complaint and description of the event, in the patient's own words;
- An opinion on whether the injuries were adequately explained; and
- The name of the investigating officer and actions taken if the police were called.

Photographs are also valuable, and the physician should ask the patient for permission to take them.

*Keep in mind the following tips:*

- When possible, take photographs before the treatment is given.
- Use color film and a color standard.
- Hold up a coin, ruler or other object to illustrate the size of an injury.
- Include the patient's face at least once. ■

Source: *American Medical News*.

## Family violence

(Continued from page 19)

aged local support of family violence programs, said Ellen Johnson, president of the county medical society auxiliary. The success of the drive has encouraged the auxiliary to plan another one next year, she added.

The ISMS Auxiliary currently is studying additional ways for ISMS members and their spouses to educate themselves and their communities about the domestic violence issue, said Carol Gapsis, Auxiliary president.

Dr. Dekker encouraged physicians to educate themselves and volunteer their medical services to local agencies such as shelters for homeless women and their children.

"We must remember that domestic violence is treatable and also preventable," said Dr. Dekker. "Doctors just have to be aware of these issues and must be willing to get involved." ■

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# New state code specifies DNR requirements

*Illinois' Do Not Resuscitate policy helps physicians broach a difficult subject. By Kathleen Furore*

When "Michael," a terminally ill cancer patient in the process of being admitted to a hospice program, suffered respiratory problems, distraught family members did what many in their situation often do: They phoned 911 for help, even though they'd made the difficult decision not to resuscitate.

But when an ambulance arrived, Michael was fully coded and medicated and received CPR — despite the family's wishes and the presence of a hospice counselor. The reason? No one had completed a Do Not Resuscitate form.

"It was a real difficult circumstance," recalled Connie O'Neill, director of admissions at the Lombard office of Vitas Innovative Hospice Care (formerly Hospice Care/Chicagoland), the organization involved in Michael's case. "Even though everyone was trying to explain that he didn't want to be resuscitated, the emergency medical personnel had a legal responsibility to do all they could to save him because they had been called."

What happened to Michael and his family is unfortunate, at best. But it can be prevented if patients and their families understand the steps they must take to institute a DNR order. And physicians can help by initiating a dialogue about the sensitive issue of DNR.

Until recently, Illinois had no policy regarding DNR orders in emergency medical situations outside of hospitals. That lack of guidelines made it difficult for doctors to discuss specifics of the topic with their patients.

In December 1991, however, the Illinois Department of Public Health instituted a Do Not Resuscitate policy that not only defines DNR but also specifies what an order must contain to be honored by emergency medical personnel called to hospices, homes and nursing homes. In addition, it mandates that every emergency medical services system in the state develop a DNR policy to be reviewed and approved by IDPH before implementation.

"This policy is great for physicians, because it tells them what EMTs are required to look for," said Leslee Stein-Spencer, IDPH chief of emergency medical services and highway safety. "It gives doctors an idea of what they can tell their patients about DNR."

**THE NEW STATE CODE** defines DNR as the "withholding of cardiopulmonary resuscitation (CPR), electrical defibrillation, tracheal intubation and manually or mechanically assisted ventilations, unless otherwise stated on the DNR Order."

The state code requires all policies to include "specific procedures and protocols for cardiac arrest/DNR situations arising in long-term care facilities, with hospice and home care patients, and with patients who arrest during interhospital transfers or transportations to or from home ... and for withholding CPR in situations where explicit signs of biological death are present. ..."

Most helpful for physicians, it tells exactly what an acceptable DNR order must include.

According to the department, a valid



DNR order must be a written, unrevoled document containing the patient's name; the name and signature of the attending physician; the effective date; the words "Do Not Resuscitate"; and evidence of consent, which can include the signature of the patient, legal guardian, durable power of attorney for health care agent or surrogate decision maker, or an attached living will or other advance directive prepared by or on behalf of the patient.

"If it includes that information, it is legally binding no matter what form it is on," said Stein-Spencer, noting that the state does not have a universally accepted DNR form.

Illinois is not the only state to address DNR in emergency medical situations. North Carolina uses a special Do Not Resuscitate order form approved in late 1990 by the state medical society and the attorney general, according to Penny Hodgson, director of communications at the North Carolina Medical Society.

**AS IN ILLINOIS**, in North Carolina, the DNR document allows emergency medical personnel to forgo cardiopulmonary resuscitation in the event of cardiorespiratory arrest. And like its Illinois counterpart, the DNR order must be signed and dated by a patient's attending physician and include the notarized signature of the patient, spouse, guardian or next of kin, or a notarized advance directive. North Carolina, however, accepts only one specially designed DNR form.

No matter how well DNR is defined

or how strongly ethicists believe doctors should counsel patients about end-of-life treatment, the issue remains a sensitive one within the medical community.

Even at Vitas, where patients must be diagnosed as incurably ill by a physician to participate in the program, O'Neill said she sees a reluctance by some physicians to initiate DNR discussions.

"I find that doctors take varying degrees of responsibility [for discussing DNR orders]. Some physicians are extremely sensitive about it and have broached the subject ... some are not clear about it at all and look to the institutions to handle it," said O'Neill.

**T**he biggest reason doctors don't like to discuss it is because it's uncomfortable and they don't want to upset their patients.

One who does broach the subject is Gary Kay, M.D., an oncologist in Elk Grove Village.

"I address it almost without exception ... in my specialty [because] it is such a pressing issue," said Dr. Kay. "But I just don't hit patients out of left field with the topic. Generally, over the course of time, patients will bring up related issues that leave me an opening."

Dr. Kay said those openings are created when patients express concerns about

how family members will fare "if something happens"; about getting their affairs in order; and about people being kept alive indefinitely by artificial means.

The oncologist, however, empathizes with peers hesitant to discuss the emotion-wrought issue.

"I think the biggest reason doctors don't like to discuss it is because it's uncomfortable and they don't want to upset their patients," said Dr. Kay. "It also forces us to recognize the fact that our best efforts and interventions are not always going to work."

Debra Susie-Lattner, M.D., an internist in Hoffman Estates and Roselle, is another physician who discusses DNR — though not easily — with her patients.

"As a matter of course, if a patient has a serious or life-threatening illness, I'll bring it up. If someone is very ill, it's a lot easier," said Dr. Susie-Lattner. "But if a patient is very healthy, it's hard to set the stage."

When she does tackle the topic, Dr. Susie-Lattner said she starts by asking a general question: "If you should become very ill with disease or a process from which you don't have a good chance of recovery, how aggressive would you like the doctors to be?"

She follows by explaining procedures including ventilation, intubation and CPR, then asks patients if they've ever discussed the issue or experienced such problems with a family member.

"It's best to get an idea at first about what a patient's background is," said Dr. Susie-Lattner, who always discusses the issue with patients in private if they are alert and capable. If not, she talks to the family. ■

*Editor's note: For more information about the IDPH DNR policy, contact Leslee Stein-Spencer at (217) 785-2080; 525 W. Jefferson, Division of EMS, Springfield, IL 62761.*



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## Trauma centers

(Continued from page 5)

in too many cases, Christ Hospital – stable patients in those areas are taken a bit farther, to one of the mid-city centers.

According to Dr. Smith, a review of data since the 1990 change shows the plan has not resulted in a single bad patient outcome.

"Redistributing patients has allowed us to keep going," he said. "I think if everybody works together – institutions, lead agencies, providers – they can come up with solutions. That's been a strength of our system."

Another change in the original Chicago

go system involved triage protocol. In the early days, only 1.8 percent of all Chicago trauma victims were taken to Level I centers. "We knew that we weren't capturing enough, because one-third of all the trauma deaths were occurring in non-trauma-center hospitals," said Dr. Barrett. Working with the Project Medical Directors Consortium, Dr. Barrett helped revise the triage criteria. Since July 1991, the centers have been capturing the nationally recommended 5 percent.

Such statistics are available because both the state and city keep trauma registries. "We just completely redesigned the system," said IDPH Director John R.

Lumpkin, M.D. "We'll be using it to evaluate outcomes. Right now we're starting to evaluate issues. For example, are Level I centers performing better than Level II centers?"

Now that Chicago has become Region XI, statewide interpretations will be possible. "With the development of the unified trauma registry, we can begin to focus not only on managing traumas when they occur, [but] we can also spend more time on preventing injuries," said Dr. Lumpkin.

The main problem for trauma systems everywhere continues to be funding. In December 1990, the system received a \$5 million grant from the state, to be

divided among state-designated Level I trauma centers. When Chicago dropped home rule, it received \$3.2 million from the state, according to Dr. Barrett.

Recently, states were allowed to apply for federal funds to help maintain or start up systems. The total national appropriation, however, is only \$5 million.

Dr. Barrett called the federal funding "a drop in the bucket. It has been estimated that \$12 million a year would stabilize the system in Chicago," he said. "If you poured that into AIDS or maternal mortality it wouldn't make a dent. But if you put it into trauma, it would fix the problem." ■



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## Edgar signs self-referral restrictions

(Continued from page 1)

the legislation is that restrictions do not extend to patient referrals made to facilities in which doctors themselves treat the referred patients. The bill also does not prohibit referrals to other physicians within a group practice.

The issue of what constitutes "outside their practice" will require delineation by the Illinois Health Facilities Planning Board.

The Act applies not only to physicians but to all Illinois licensed health care workers such as dentists, nurses, clinical psychologists, social workers, pharmacists, physical therapists, podiatrists and optometrists. The legislation mirrors the American Medical Association's Council on Ethical and Judicial Affairs report on self-referral. That report, like the Illinois measure, states that physicians should refrain from referring patients to facilities they own if they do not treat patients there. The self-referral bill was sponsored by Sen. William A. Marovitz (D-Chicago).

"It's important to point out that this bill is preventive in nature," Illinois State Medical Society President Arvind K. Goyal, M.D., told *Illinois Medicine* in July, after the bill was passed by the General Assembly. "We don't perceive any current problem with referral abuses in Illinois. But legislation that would significantly impact the availability and provision of health care services was introduced and was advancing before ISMS got involved. This is not a bill the medical society sought in Springfield, but it was sought by the Illinois chapter of the American College of Radiology. ISMS worked hard to assure that its provisions include a fair and reasonable approach to regulating self-referrals. It's a difficult issue."

Dr. Goyal cited the key role to be played by the IHFPB in defining key terms, writing rules to implement the legislation and determining appropriate referrals under the Act. Health care workers can ask the board for advisory

rulings to determine whether current or proposed referral arrangements are permissible under the bill's provisions. "The bill gives the planning board the flexibility to apply the law in a fair and objective manner," Dr. Goyal said.

For example, the planning board holds responsibility for determining the appropriateness of self-referrals to health care worker-owned facilities in communities where a "demonstrated need" exists and

*"ISMS worked hard to assure that its provisions include a fair and reasonable approach to regulating self-referrals. It's a difficult issue."*

**ISMS PRESIDENT  
ARVIND K. GOYAL, M.D.**

alternate funding for the facilities is not available. The planning board can exempt from the restrictions certain referrals that meet these criteria.

These referrals must still meet certain requirements. For example, health care workers are required to disclose to patients their financial interest in the referral facility. And if other facilities in the community offer the same services, the physician must offer the patient a choice between facilities.

The restrictions do not extend to referrals to facilities with stocks publicly traded on the open market, such as the New York Stock Exchange, with assets of more than \$30 million. However, even in these large facilities, the bill states, a physician's income from the investment cannot be tied to the number

of referrals a doctor makes and the health care provider cannot own more than .5 percent of the total equity. The bill specifies other restrictions as well.

Although the bill limits many referrals for health care services, it does not apply to referrals for "goods." For example, physicians can refer patients to facilities they own for the purchase of medical supplies or appliances.

The bill applies to referrals for health services made on or after Jan. 1, 1993. If health care workers acquired an investment interest before July 1, 1992, however, the bill does not apply to referrals made for health services before January 1, 1996.

Violating the referral restrictions could result in disciplinary action for health care workers and in civil monetary penalties of up to \$20,000 for each illegal referral made by entities other than health care workers.

**TWO PHYSICIANS WILL NO LONGER** be required to serve as witnesses at state-ordered executions, but a doctor will still be required to pronounce the death of the executed inmate. Under the ISMS-supported legislation, only six witnesses — who need not be physicians — instead of the current eight, will be required at future executions.

A bill removing both the physician witness and pronouncement of death provisions from the Illinois Criminal Code passed the House in the first half of the session but stalled in the Senate. Legislators balked at attempts to amend the bill by eliminating confidentiality safeguards for physicians who choose to participate in executions, language that would have brought state law in line with ISMS policy adopted at the ISMS House of Delegates annual meeting in April.

The confidentiality amendment caused Sen. Robert M. Raica (R-Chicago) to withdraw his sponsorship shortly before the session ended in June. The Illinois Department of Corrections and attorney general's office also fought the confidentiality amendment and the elimination of

the requirement for doctors to pronounce death, calling those changes a "back-door attempt to abolish the Illinois death penalty law." Legislators and attorney general's office officials said they viewed these provisions as an attack on the death penalty, not a protection for physicians.

Any further attempts to ban confidentiality for physician-participants in state-ordered executions or to lift the declaration of death requirements must wait until at least the fall veto session in November. ■

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## Physician assistance

(Continued from page 1)

physicians experiencing alcohol or drug abuse problems, or physical or psychiatric disorders. "This is a busy, positive program," said Committee Chairman James C. Leonard, M.D. "We're helping impaired physicians get back to practice."

The program offers five services: confidential consultation for impaired doctors or anyone concerned about a doctor's ability to perform; investigation of concerns or allegations of impairment; intervention when necessary and referral for assistance and treatment; case management and continuing care; and advocacy.

This positive approach leads to positive results, said Martin C. Doot, M.D., vice president of medical services at Parkside.

"About 34 percent of the physicians who enter [the program] are self-referrals," Dr. Doot said. "This tells us that they trust the Physician Assistance Program as an advocacy program, rather than viewing it as disciplinary. Although it may be hard for physicians, whose work demands perfection, to admit to having a problem, they're trusting us, and the message is getting out that there is help available."

Smaller percentages of colleagues, family members and work associates also help impaired physicians enter the program, Dr. Doot said. These cases may

involve a concerned party's contacting the program to voice concern about a physician's possible problem, leading to a confidential investigation. Or a group of concerned family and friends may choose to hold an intervention to confront the impaired physician and spur him or her into treatment.

The ISMS committee focuses not only on helping impaired doctors, but on training physicians and hospital staff in conducting interventions.

Another positive factor for the program, said Dr. Doot, is that nearly three-quarters of all participants are in active treatment or the continuing-care phase of treatment.

"This means that they're complying with their treatment instructions," said Dr. Doot. "And compliance relates to positive outcomes. The key is keeping people in care. Those who continue to get help are more likely to stay well."

The Illinois Department of Public Health requires hospital medical staffs to assist their staff members in addressing physical and mental health problems. To help medical staffs comply, the ISMS committee has developed a kit that outlines how to set up a physician assistance committee.

In the Peoria area a group of physicians has come together because of a mutual interest in helping impaired physicians, said James L. Early, M.D., a former ISMS Physician Assistance Committee member.

"We call ourselves the Downstate Physicians' Assistance Group," he said, "as opposed to a committee or organization. We aren't a formalized unit, just an interested group that understands the scope of the problem and discusses general topics and offers assistance and support when needed."

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MARTIN C. DOOT, M.D.

According to Dr. Early, members of the group represent the area's three hospitals — Methodist, Proctor and St. Francis — and serve as a resource pool, helping with interventions when necessary. They don't discuss assistance case by case, but stick to general concerns for physicians in the region.

The benefits of such a regional setup are to spread the educational process to all hospital staff members, avoid possible conflicts of interest that may occur in a single-hospital setting and reduce legal risk for referring physicians and/or committee members.

"Regional groups like the one in Peoria can offer a network to allow people to get help before performance is affected," said Dr. Early. "The key issue is to identify a potential problem in the medical community before it becomes a danger."

Working with a group of hospitals and training all staff to recognize indicators of substance abuse, emotional problems or Alzheimer's disease, for instance, bring impairments "out of the closet and into the public eye," Dr. Early added.

"For physicians with a problem, it's difficult to be open because of their position in the community. They need to admit that, in a profession where perfection is needed, they may not be perfect."

The number of physicians calling the physician assistance program and getting the help they need, said Dr. Doot, is on the rise.

"It's great to see that the word is getting out. The more the medical community hears about physician assistance programs, the better," he added. "A doctor may not need us now, but if a crisis ever arises, he or she will know where to call and get help."

## Resident physicians

(Continued from page 1)

One of the main barriers to recruiting resident members has been "getting the word out," said Mark Bair, M.D., chairman of the ISMS Resident Physicians Section. "In medical school, you get a lot of exposure to organized medicine because the Society has representatives everywhere." However, that is not the case in residency programs, where the "exposure is zero." Therefore, to educate residents about the importance of

membership in organized medicine, the Society must establish a channel of communication with them.

With that objective, the medical society designed a direct mail campaign to introduce residents to ISMS. The concept evolved from a 1991 survey of 2,000 resident physicians throughout the state that asked what types of professional information interested them. Residents' comments revealed that no one direct mail piece could adequately address each individual's information needs. Customized kits, tailored to each resident's medical interests and concerns,

were required.

The new resident brochure and information kits offer just that. The brochure provides membership information and a glimpse of 15 ISMS publications and activities that can be helpful to residents as they embark on their medical careers. These include the Illinois Medical Practice Act, the New Physicians' Handbook, the Professional Liability Kit, and information about provider contracts and advance directives, among other professional issues. Residents can request any of these materials through a postage-paid order form.

In July, ISMS distributed 1,500 copies of the new resident brochure to residents through the 90 residency program directors. Response to the new brochure has been good; 185 informational kits have been requested to date.

In addition to a lack of communication with residents, time constraints and the perceived cost of membership influence the low levels of resident participation in ISMS, according to Dr. Bair. "I don't think they know that the cost of membership is not great. And I don't think they truly understand what they would receive in return," he said.

"The most important thing the Society offers residents is the opportunity for their voice to be heard and the opportunity to present their concerns at the county, state and national levels," Dr. Bair continued. "Organized medicine is the strongest government lobby for physicians. [Government] policy decided today will dictate our practice in the future. It's important for us to help shape that policy."

Through the ISMS Resident Physicians Section, which was established in 1986, residents can make their voices heard. The Resident Physicians Section sends a delegate to the ISMS annual meeting, where policy is established, and the Section's chairman reports to the ISMS Board of Trustees, keeping leadership informed of issues affecting residents. This year, the residents' successful efforts resulted in the passing of state legislation to prevent government interference in the regulation of resident and intern work hours. Efforts continue to address concerns about residents' increasing difficulty to repay student loans.

"Each resident who joins is giving us strength, providing us with some additional funding and with new people to train for leadership positions in the future," said Dr. Bair. "That is why membership is so important."

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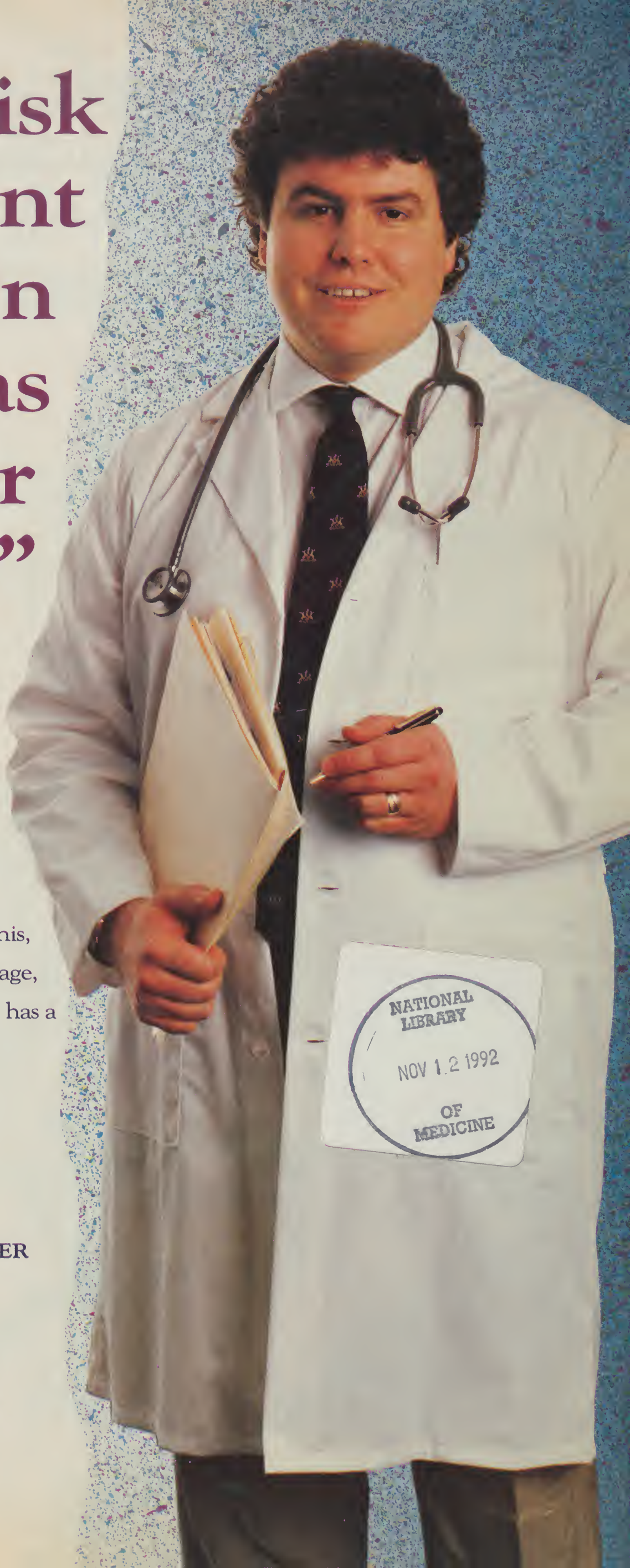
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**Teen health concerns**  
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# Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • OCTOBER 23 1992



**Key Illinois House races**  
PAGE 16

## CDC lowers acceptable blood lead level for children

**LEAD:** As lead poisoning continues to be a problem, the CDC releases a new threshold and action guidelines for prevention and treatment. By Stacie Crozier

[ CHICAGO ] A very real problem in the 1990s, lead poisoning affects some 3 million to 4 million preschool children across the board in the United States. Taking aim at the problem, U.S. Department of Health and Human Services Secretary Louis W. Sullivan, M.D., announced Oct. 7 a new and lower "threshold of concern" for lead levels in children's blood, adopted by the U.S. Centers for Disease Control, as well as corresponding "levels of action" that need to be taken in response to lead poisoning.

The new blood level adopted by CDC - 10 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ) of whole blood - is less than half the 25  $\mu\text{g}/\text{dL}$  level identified as unsafe by the health agency in 1985. According to the CDC's document "Preventing Lead Poisoning in Young Children," blood lead

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M. CANDEE STUDIOS



**THE ILLINOIS STATE** Medical Society sponsored a luncheon and roundtable discussion Sept. 27 in Chicago to honor a visiting delegation of Russian women educators (at left). The discussion focused on how the private and public sectors address the health care needs of women in Illinois.

## Presidential candidates square off on health care reform and funding

**REFORM:** Republican and Democratic presidential candidates offer differing approaches to health care reform.

[ CHICAGO ] Underscoring the differences in their approaches to government, President Bush and Democratic presidential candidate Gov. Bill Clinton have presented very different plans to reform the country's problems in health care delivery and financing.

The 1992 presidential campaign is the first where health care played a prominent role.

In late September the American Medical Association, the American Association of Retired Persons and the AFL-CIO called on the two candidates to debate health care, and health care reform was a topic

during the presidential candidate debates. Here, in capsule format, is a review of the proposals.

**PRESIDENT BUSH'S HEALTH** care plan was sent to Congress in February.

The Bush plan is directed toward making it easier for small businesses and individuals to afford health insurance in a subsidized marketplace approach. Clinton focuses on global budgets and national health care spending targets.

Bush would give vouchers to the poor so that they could purchase health insurance. Middle-class taxpayers would get tax credits - up to \$3,750 for a family of three or more, based on income - for health insurance premium expenses. Self-employed people would be allowed to deduct 100 percent of their health insurance costs.

The president's plan would limit yearly premium increases



President Bush



Gov. Clinton

and would make it easier for small businesses to purchase coverage for employees. Pre-existing condition limitations would be phased out, and small businesses would be encouraged to form purchasing networks to obtain cheaper insurance rates.

The Bush plan cost-control measures include an emphasis on managed care. The president says savings would result from administrative streamlining, emphasizing preventive care, limits on malpractice awards (see story, page 5), insurance industry reforms and the adoption of "coordinated care."

(Continued on page 4)

## ISMS AND THE COMMUNITY

### ISMS TO EXPLORE WHAT WORKS IN INDIGENT CARE

Illinois physicians are reaching out to their communities and one another for support in establishing programs to care for those who can't afford it.

The Illinois State Medical Society is sponsoring a conference to bring together physicians, hospital administrators, politicians, religious groups, and business and community leaders to discuss various health care delivery alternatives for low-income patients. The conference, "Indigent Care: What

Works?" will be held Friday, Nov. 20, at the Holiday Inn in Joliet.

"Many solutions to our health care crisis can be found right in our own neighborhoods," said Arvind K. Goyal, M.D., ISMS president. "Several communities across the state have already taken innovative and important initial steps to improve access to medical care for their indigent population. Through this conference, the Illinois physi-

(Continued on page 25)

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## SIU ranks first in AAMC survey

[ SPRINGFIELD ] Southern Illinois University School of Medicine ranks first nationally in the percentage of its graduates who practice medicine in a primary care specialty. According to a survey by the Association of American Medical Colleges, only two medical schools of the 126 in the United States had more than 50 percent of their graduates practicing in a primary care specialty. SIU's 53.7-percent ranking was the same as that of the East Carolina School of Medicine in Greenville, N.C. The national average is 26 percent.

"We are delighted with this top ranking, which shows how well we have addressed our mandate to help Illinois meet its need for primary care physicians," said Richard H. Moy, M.D., SIU's dean and provost. "We are a relatively young medical school, but we always have exerted considerable effort to see that we are helping meet the state's No. 1 medical manpower need."

"Primary care needs to be beefed up," said Fred Z. White, M.D., a member of the ISMS Health Care Access Committee. "The need for primary care physicians is great. SIU's efforts are a step in the right direction."

Dr. Moy said there are numerous reasons for SIU's success in training primary care physicians. Medical students are required to take a six-week

family practice clerkship with a downstate physician before they decide on their specialties, he said. "Starting as freshmen, our students work alongside a variety of faculty and community physicians, all of whom have their own commitment to downstate medicine. Many of them joined our faculty because of our dedication to meeting the primary care needs of the state."

SIU also admits a high percentage of women, who often select a primary care specialty, he added.

A recent SIU survey of its alumni showed that more than half of its graduates in practice entered either family practice, general internal medicine, general pediatrics, or obstetrics and gynecology — all considered primary care specialties. Of the school's 405 graduates currently in practice, 60 percent have settled in Illinois or one of five contiguous states.

SIU also ranked high in two other categories in the AAMC survey. The school ranked 22nd in the percentage of minority graduates, with 10.8 percent, and 39th in the percentage of graduates accepting in-state residencies, with 51.5 percent. Other AAMC categories tallied percentage of graduates who are medical school faculty and total federal research grants and contracts. ■

## Copley replacement facility breaks ground

[ AURORA ] Copley Memorial Hospital broke ground Sept. 21 for its \$67 million replacement facility, to be located in the southeastern corner of Kane County. Preliminary site development is scheduled to begin this fall, with construction set for early 1993 and occupancy for late 1995.

The new hospital will feature ambulatory services, women's services, oncology services and physical rehabilitation services.

Copley received approval of its plans to replace its current facility from the Illinois Health Facilities Planning Board in July. The hospital's first choice for a replacement facility site was rejected by the planning board because the board said the DuPage County site would create a glut of services. Copley is an affiliate of Rush-Presbyterian-St. Luke's Medical Center of Chicago. ■

## State tests more than 100,000 for HIV; 3 percent found positive

[ SPRINGFIELD ] Since late 1985, more than 100,000 Illinoisans have used state-funded counseling and testing sites to be screened for HIV, said John R. Lumpkin, M.D., director of the Illinois Department of Public Health.

Of the 101,362 tested, 3,055 (3 percent) were positive for HIV antibodies.

The first 50,000 people were tested in a little more than six years, but the second 50,000 were tested in less than 18 months. More than 35,000 people received counseling and testing in 1991, and 18,029 were tested in the first half of 1992.

"The increasing number of those seeking testing for HIV confirms our belief that more and more people are taking the threat of HIV and AIDS seriously," Dr. Lumpkin said. "However, despite



M. CANDEE STUDIOS

**TWENTY-NINE HOSPITALS**, HMOs and clinics hoping to recruit internists participated in Career Opportunities Day for Internal Medicine Sept. 19 at Rush-Presbyterian-St. Luke's Medical Center in Chicago. About 100 physicians attended the event, which was sponsored by the Illinois Society of Internal Medicine, the Illinois Chapter of the American College of Physicians, and the Resident Physicians Section of the Illinois State Medical Society.

this progress we believe many of those who are HIV positive are unaware of their infection and may unknowingly be spreading this deadly disease. We must continue to encourage people who may be at risk of HIV infection, whether it is through unprotected sex or sharing drug needles, to be tested for HIV."

According to IDPH, 7,450 AIDS cases have been recorded in Illinois since 1981. Since reporting of HIV infection was mandated in 1988, 9,612 people have been reported as HIV positive. More than 4,900 (68 percent) of the Illinois AIDS cases reported male homosexual or bisexual contact, and 1,126 (15 percent) disclosed drug injection.

Of the counseling and testing center clients, 56 percent were males and 44 percent females. Of the men tested, 4.8 percent were HIV positive, compared with 1 percent of the females.

Sixty percent of those tested were white (1,280, or 2.1 percent, positive); 32 percent African-American (1,338, or 4.1 percent, positive); and 6 percent Hispanic (385, or 6.8 percent, positive).

HIV counseling and testing are offered

on a confidential basis at sexually transmitted disease clinics statewide and some substance abuse, family planning, prenatal and tuberculosis clinics. ■

## Chicago Health Department expands West Side mammography services

[ CHICAGO ] Expanding its mammography services to women on the city's West Side, the Chicago Department of Health in September began offering mammograms at two additional neighborhood clinics. Mammograms are now being offered at the Lower West Side Neighborhood Health Center, 1713 S. Ashland, and at the West Town Neighborhood Health Center, 2418 W. Division.

"Last year, well over 500 women in Chicago died from breast cancer," said Chicago Health Commissioner Sister Sheila Lyne, R.S.M., in a release announcing the services. "On average, that's a death every 16 hours. There is no doubt that a number of those women could have been saved had their cancer been detected earlier than it was. Our expansion of service is designed to provide that crucial early detection service in neighborhoods that really need it."

Mammography services have been available on the city's South Side at the Englewood Neighborhood Health Center, 641 W. 63rd St., and the Roseland Neighborhood Health Center, 200 E. 115th St.

The National Cancer Institute recom-

## PHYSICIAN FACTS

### Alcohol, tobacco and drug use among U.S. high school seniors

#### Percentage of high school seniors using:

Health indicator	1980	1985	1990	1995 goal
Alcohol: 5 or more drinks at one time in the last 2 weeks	41	37	30.0	20
Cigarettes: daily in last 30 days	22	20	18.5	14
Cocaine: last year	12	13	3.5	2
Crack: last year	n/a <sup>2</sup>	n/a	1.5 <sup>1</sup>	1
Marijuana: last year	49	41	24.0 <sup>1</sup>	14

1 — 1991 statistics; 2 — figure not available

Data reprinted from American Health Foundation Youth Health Report Card, 1992.

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mends that every woman between 40 and 50 years old get a mammogram every one to two years, and that women past age 50 have one annually. ■

## Sears offers mail order prescriptions in catalog

[ SKOKIE ] Sears, Roebuck and Co. announced it will offer a new prescription mail order service through its 1992 fall catalog and 1992 health care catalog — a first for a mass-marketing company of its kind. The prescription service, run by the Allscrips Mail Service Pharmacy, will reach an estimated 6.5 million customers through Sears.

Sears is promoting the service as offering "tremendous savings," saying, "It's like having a drugstore right at home."

The service offers 10,000 prescription drugs, listing only a fraction of those in the catalog. Customers may call a toll-free number to order drugs not listed. Allscrips' staff of 30 "trained, licensed pharmaceutical professionals" will contact physicians to verify prescriptions and will mail prescriptions within 48 hours of the order.

Sears said the convenience of having maintenance prescription drugs delivered to the home could increase patient compliance with prescribed therapies. Sears is advising customers to ask their physicians to prescribe generics whenever possible for further savings, and is offering up to 30-percent savings on generic equivalents.

Allscrips Pharmaceuticals Inc. provides dispensing systems to physicians, clinics and other health care providers to reduce prescription cost and improve patient convenience for acute care prescription medications, Sears said. The company also provides mail-service maintenance-prescription benefit programs to companies in funded benefit plans nationwide. ■

## ISMS brochure aids CLIA compliance

[ CHICAGO ] Enclosed with the Oct. 9 issue of *Illinois Medicine* was a brochure to help physicians comply with the Clinical Laboratory Improvement Amendments.

The brochure, "The Clinical Laboratory Improvement Amendments: What You Should Know," was developed by the Illinois State Medical Society's Council on Medical Services and Committee on Blood Banking and Laboratory Services.

Physicians who have reviewed the brochure and still have questions about CLIA compliance may call the ISMS department of medical services at (312) 782-1654 or (800) 782-ISMS. ■

**THE ILLINOIS STATE MEDICAL** society conducted its fifth annual CME planners workshop, "CME Benchmmarks for the '90s," Oct. 2 in Rosemont. Speakers pictured at right are (from left): Peter H. Rheinstein, M.D., J.D., M.S., director of the Office of Health Affairs Medicine Staff of the U.S. Food and Drug Administration; Donald F. Pochyly, M.D., chairman of ISMS' Council on Education and Manpower; Dennis K. Wentz, M.D., director of the AMA Division of Continuing Medical Education; and Upjohn Co.'s David Lichtenauer.



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**REPORT**

**FOR *Illinois Physicians***

### 1993 LIMITING CHARGE REDUCTIONS INCREASE THE BENEFITS OF PARTICIPATION

Effective with dates of service January 1, 1993, the Limiting Charge for non-participating physicians will be reduced to 115% of Medicare's approved amount for non participating physicians rendering the service. This reduction eliminates the provider-specific aspects of Limiting Charge in that the 1990 and 1991 comparisons of the percentage by which the Limiting Charge exceeded a provider's Maximum Allowable Actual Charge (MAAC) no longer apply. The limiting charge will be the same for all non participating physicians in the locality.

Given the fact that participating providers receive an across-the-board 5% advantage in their approved amounts over those of non-participating providers, the financial advantages of collection for the non-participating provider are greatly diminished.

In mid-November, all Medicare B providers will receive their annual disclosures, or charge reports, indicating Medicare's approved amounts and limiting charges for the services they bill. This mailing will be preceded by the Dear Doctor Letter and Fact Sheet on Participation. Providers are encouraged to review these documents carefully, perhaps seeking the consultation of a financial advisor, to determine whether or not the time is right for them to choose participation.

In addition to higher approved amounts, numerous other incentives are offered to the participating provider, and are listed below:

- As the participating provider contractually agrees to accept assignment for all covered services for their Medicare B patients, **payments are mailed directly from the carrier to the provider**, thus eliminating any potential collection problems.
- **Approved amounts for participating providers are 5% greater** than those of non-participating providers.
- As all claims from participating providers must be submitted on an assigned basis, **payment turn-around time may be as much as 10 days faster** than payment to the beneficiaries of non-participating providers who do not accept assignment.
- Participating providers receive specially designated telephone numbers and PO Boxes for **faster, preferential service** with the carrier.
- Participating providers receive complimentary advertising through **publication in the annual MEDPARD** (Medicare participating Physician/Supplier Directory).
- As participating providers agree to accept assignment, they are **not limited by the Limiting Charge** in any of the actual charges they file with Medicare Part B.

December will mark the annual open enrollment period for participation. Providers who wish to participate should complete the Participation Agreement accompanying the Dear Doctor Letter and Fact Sheet on Participation and return it to the address listed below no later than December 31, 1992:

Medicare B  
Provider Certification  
PO Box 994  
Marion, IL 62959



## Edgar modifies allied health practitioner bills by signing amendments

**BILLS:** Gov. Jim Edgar wraps up action on bills important to physicians by amending legislation authorizing licensure of naprapaths and clinical professional counselors. By Kevin O'Brien

[ SPRINGFIELD ] Capping action on health-related bills on his desk, Gov. Jim Edgar approved amendments to two allied health practitioner bills, making them somewhat more palatable to Illinois physicians.

S.B. 1662 amends the Clinical Professional Counselor Licensing Act, S.B. 2056, to exempt allopathic and



osteopathic physicians from the Act's licensure requirements. The Illinois State Medical Society had urged the governor to veto the clinical professional counselor bill, but Edgar signed the measure Sept. 3. The amendment, which the governor approved Sept. 25, was necessary to ensure that physicians

already licensed under the Medical Practice Act would not have to fulfill dual licensure requirements.

S.B. 1662 also amends the Naprapathic Practice Act, S.B. 1468, which received the governor's amendatory veto Sept. 25. The amendment strengthens the grounds for discipline, requiring naprapaths to treat only individuals with a referral and documented diagnosis

from a physician, dentist or podiatrist.

Fiscal considerations prompted the governor to recommend delaying the effective date of the naprapath's bill to July 1, 1993, and to increase the fees required for licensure. The Senate must approve Edgar's changes.

**Demonstration projects** for subacute care hospitals were authorized under S.B. 837, which the governor signed Sept. 24. The Act defines a subacute care hospital as a "designated site which provides medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility, but who no longer require acute hospital care." The legislation is effective immediately.

Such facilities may be freestanding or distinct operational entities within hospitals. Subacute care hospitals will be subject to certificate of need requirements and must have a contractual relationship with an acute care hospital, among other provisions. The bill authorizes up to two subacute care hospital demonstration projects for each of the following areas: the city of Chicago; suburban Cook County; DuPage, Kane, Lake, McHenry and Will counties; other municipalities with populations exceeding 50,000; and rural areas.

**Improved rural health access** is the intended result of a bill requiring the IDPH Center for Rural Health to cooperate with the University of Illinois in creating programs to encourage primary care physicians to practice in rural areas. Edgar signed the measure Sept. 18. ■

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## Health care reform

(Continued from page 1)

**DEMOCRATIC CANDIDATE** Clinton's plan would cap national health care costs, provide basic universal coverage and establish publicly sponsored purchasing groups to drive down insurance costs. Additional insurance reform would come from moving from experience rating to community rating.

Clinton's plan includes alternative dispute resolution and practice guidelines as tort reform proposals. National spending targets would be set by a national health care board made up of consumers, providers, business, labor and government. To meet those budgets, state boards would give health care networks a fixed amount of money to meet a patient's needs for the year. Those state boards would also establish fee schedules for doctors and hospital services.

Under Clinton, employers would be required to provide at least basic coverage (including prenatal care, routine physicals and prescription drugs) for employees. Small firms would get tax credits to help them meet the government requirement to insure employees. Clinton resists having his plan described as a version of "pay or play": The tax credit to small businesses, a recent addition to his plan, moves his version of health care reform closer to a national version of the Hawaiian system.

The unemployed could purchase coverage under the public plan, which Democrats estimate could be expanded due to administrative cost savings. ■



# The critical difference: Bush vs. Clinton on tort reform

[ CHICAGO ] Whatever confusion and vagueness may be claimed about the health care reform plans of President Bush and Gov. Bill Clinton, a very real – and, for medicine, very critical – difference lies in their approach to medical malpractice tort reform.

The plan promoted by Bush calls for a series of tort reform actions, including providing incentives to states to eliminate joint and several liability for noneconomic damages; cap noneconomic damages; eliminate rules allowing double recovery and promote pretrial alternatives.

The Illinois State Medical Society has worked successfully in the Illinois General Assembly for most of the measures the president supports. Yet to be passed by the legislature is a cap on noneconomic damage awards, which would help control excessive awards.

On the other hand, something there is

that does not love a lawyer, to badly misquote Robert Frost; and Clinton, a Yale Law School graduate and former professor at the University of Arkansas law school, has been targeted by physicians for what some perceive as his “soft” position on tort reform, a position many feel is underscored by the plaintiff’s bar’s general support of the Democratic slate. Clinton has said he favors alternative dispute resolution and practice guidelines as tort reform.

According to an article in the Aug. 31 issue of *Forbes*, Philip Corboy, identified by the magazine as “Chicago’s undisputed king of torts and general counsel of the Democratic Party in Illinois” is confident Clinton sees no need to fiddle with the current tort system. What makes Corboy certain that Clinton thinks the system is just fine as it is? “I just looked him in the eye and asked him,” *Forbes* reports Corboy as saying.

Corboy has since funneled more than \$50,000 to the Clinton campaign, *Forbes* notes. And a CNN-sponsored study conducted by the National Library on Money and Politics found that “lawyers” are the biggest contributors to the Clinton campaign.

Even more damning language comes from a letter by David H. Williams, former president of the Arkansas Trial Lawyers Association, in which he tells his colleagues that in the 20 years he has known Clinton, “I can never remember an occasion where he failed to do the right thing where we trial lawyers were concerned.”

Williams’ letter cites 1987 legislation prepared by the governor’s staff that contained some elements of tort reform (joint and several liability, limitations on punitive damages and changes in the collateral source rule); after the trial lawyers contacted Clinton, Williams

claims, the tort reform part of the package was pulled.

“During another session,” the letter continues, “I remember a bill that had whistled through the Arkansas House and Senate that would have given immunity from liability to ‘good samaritan’ doctors who provided medical care to indigent patients. This proposed act went to the governor’s desk for his signature ... and [he] vetoed the bill. I would say that this act took some strength of character and conviction. However, this is not unusual. Bill Clinton has always been sensitive to these kinds of issues.”

In closing, Williams recommends that Arkansas trial lawyers put their money behind Clinton – “there can be no other choice,” he says. “He’s the only choice for us trial lawyers and the little folks we represent.” ■

## Policy advisers outline candidates’ health care reform plans

Illinois Medicine asked the health advisers of President Bush and Gov. Bill Clinton what they think physicians need to know to make informed voting decisions in the 1992 presidential election.

### Clinton plan would mandate employer coverage, national health budget

Today, the health care challenge facing America – how to simultaneously assure access, promote quality and control costs – is sobering but unavoidable. Other countries have developed unique solutions, reflecting their own social and political cultures. We will have to develop a uniquely American approach.

George Bush has not shown presidential leadership. His 11th-hour proposal would not guarantee universal coverage, and would leave the inflationary and bureaucratic health care system largely intact.

Gov. Clinton, by contrast, has proposed a straightforward plan that would at long last provide both universal health insurance coverage for all citizens and a commitment to affordability. The plan builds on the current employer-

based, private insurance system. Employers would be required to insure their workers either directly or through purchasing group cooperatives. Whichever the choice, care would continue to be provided by networks of private physicians in private hospitals. In addition, the insurance industry would be transformed to better serve the public interest. Instead of profiting by avoiding risk, insurance companies would have to compete on the basis of better service. No longer will sick patients be excluded from coverage because of their conditions or their providers be financially penalized for caring for persons who are poorer or sicker than the norm.



**Robert A. Berenson, M.D.**, is a board-certified internist in private practice in Washington, D.C. He was a member of the Carter White House domestic policy staff, working on national health policy issues.

Gov. Clinton promises no magical cost-control solutions. Rather, he proposes an evolutionary process for attacking costs in a systematic, comprehensive manner. Consumers, physicians, business leaders, and others with a real stake in the cost of health care will be asked to come together to set a health budget for the nation and for the states. In general, the budget should rise no faster than Americans’ wages; it will not be set arbitrarily in relation to some economic measure, but on multiple factors, including inflation, and national productivity, population growth, new technology and changing illness patterns. Even more important, the process will include negotiations, giving physicians and other diverse membership comprising the national health board the opportunity to exchange information, and will weigh

varying viewpoints to determine the most effective and equitable approach to cost control. States will be encouraged to promote local health networks – organized systems of insurers, hospitals and doctors. National guidelines to ensure fundamental malpractice reform will be part of the process.

By internalizing the need to stay within budget, the Clinton approach places decision making with the local health networks of providers, drastically reducing the need for externally imposed micro-management. ■

### Tax subsidies and vouchers featured in President Bush’s plan

The goals are the same for both the president and his opponent. They [both] want to make sure everyone has adequate and affordable health insurance and to moderate health care spending. They differ fundamentally on the way to achieve these goals.

The president has a major, comprehensive plan that will focus [the] government’s financial resources on the poorest and neediest. Tax credits and vouchers will provide the poor with free private health insurance. For low- and middle-income Americans, the president’s plan will provide additional tax benefits to help pay for health insurance. More than 90 million Americans will benefit.

The president’s program will control costs through market reform and competition. The president’s plan includes medical malpractice reform that will limit noneconomic damages, provide payouts over time and meaningful alter-

native dispute resolution, removing the push to resolve malpractice cases in the courts. The president’s plan also will place greater emphasis on coordinated care plans, and by instituting electronic cards, common billing forms, electronic billing, and electronic medical records, will reduce the blizzard of paperwork that confuses consumers and unnecessarily drives up the administrative costs. In addition, it will provide consumers and purchasers with the information they need to make informed health care purchases, and create health insurance networks [by] encouraging small

businesses to form health insurance purchasing groups that will lower the cost of health insurance premiums. While Gov. Clinton’s health care plan is not specific, the president differs with his opponent on health care in two major ways. Gov. Clinton would create a health care board appointed by the government, which would make decisions about what health care services people would receive. Clinton would also ask the health care board to establish the amount that would be spent on health care, and the government could not exceed that amount.

The president does not want the government to decide how much will be spent on health care, using a global concept that would reshape decision making and affect the dynamic response of the U.S. government to the health care needs of its citizens. He does not want to tell employers what health care benefits they

must offer their employees. He wants to use the direct force of government to make sure physicians and the purchasers of health care are better informed. The president has concern for small-businesses and low-wage employees, as well as the economic growth of this country. The president views the physician as a small-business person who should be relieved of the heavy paperwork burden of government regulation. He wants to use government to remove the barriers to make sure that incentives work for, not against, physicians delivering excellent health care. ■



**Gail Wilensky, Ph.D.**, serves as President Bush’s deputy assistant for policy development, and is former head of the U.S. Health Care Financing Administration.



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## EDITORIAL

### 902 uh, oh

If you're not keeping up with Brenda and Dylan, Brandon and Andrea, and Donna and Kelly and Steve, you're just not keeping up at all. Now that soap operas are respectable prime time programming, it was inevitable that a teen soaper would hit the screen, and we have it in *Beverly Hills, 90210*.

Set in the fictional West Beverly Hills High School, the series features the usual teenage topics of angst: Oh, no! will the twins' father accept a promotion and make them move back to (gross!) Minneapolis? Will somebody in authority (you know, an adult) do serious injustice to Andrea's and Brandon's relationship by choosing *him* to be managing editor of the school paper, instead of her? As easy as it is to parody the show's adolescent plots, a disturbing element crops up in the program: These kids, who are role models for teens all over the country, have rotten health habits. As wealthy and hip as they're all supposed to be (and they all have great teeth, great skin and classic noses, indicating that someone has invested in at least the cosmetic aspect of their health), they practice risk-taking, life-threatening habits.

They smoke. They drink. They drink and drive, with disastrous results to Ferraris, but not to life and limb, because this is, after all, television and not real life. Even scarier, they practice unprotected sex.

In a way, this is a realistic portrayal of today's teens: their mind-set is such that they cannot, for a moment, envision

themselves as vulnerable. "It could never happen to me" is the national teenage motto. This reasoning is just as irrational as a 2-year-old's tantrum in a grocery store, except the results can be far more drastic.

Physicians have a firsthand opportunity to make a difference in the health outcomes of America's young people — through visits in the doctor's office and through outreach programs such as the "AIDS & Adolescents" speakers' bureau sponsored by the Society. We need to get a serious message to these young people to let them know that they aren't invulnerable and that we do care about them and their health. And somehow we have to get shows like *Beverly Hills, 90210* to portray healthier habits for young people, since teens pay attention to media, rather than to mom, and to peers, rather than to dad.

We need to start working on Brenda and Dylan to present positive messages. Put away the vodka and drink a glass of milk once in a while. Throw away the cigarettes and show Donna brushing her teeth, or Brandon getting a DPT booster or Donna taking her boyfriend's car keys away when he's been drinking. Let Brenda tell Dylan that she believes what she heard in health class about promiscuity and AIDS and she thinks she'll just take a pass on that groovy hotel room for prom night.

In other words, let's tell the kids in *90210* to get a life — before they wreck the ones of their viewers.

## PRESIDENT'S LETTER

### Making excuses doesn't change the facts: ISMS works for every Illinois physician and patient

By Arvind K. Goyal, M.D.



*"I am pleased to report that your medical society remains a strong advocate for your practices and your patients."*

I saw a commercial on television: An anxious man, sitting on a couch, complains to his psychiatrist, "I've been waking up nights feeling guilty about something. Like I am taking advantage of something. It's been going on too long, ever since the first of this year." The good doctor pondered a few moments, then spoke. "Could it be that you have neglected to pay your share this year while enjoying all the wonderful programs on public television?" In the final scene, the man leaves the office happy and with a commitment to make his contribution to public television!

I know only a handful of my physician colleagues who do not belong to the state medical society! The majority, 18,000 or about two-thirds, of all caring physicians in this state, are proud to be a part of the action. These good citizens carry their fair share of the load. They volunteer their time to the activities of county and state medical societies, write and call with their ideas when they feel their society can do better, and are not shy of words when they disagree! Much criticism and advice also comes from those who have elected not to join. At a recent county medical society meeting, the two physicians who complained most loudly about an ISMS policy were discovered to be non-members. Here is how I respond to those doctors who would rather complain than belong:

- "I refuse to become a member because the AMA does not represent me." The AMA cannot represent you if you aren't even a member! (Like Groucho Marx, they won't join any organization that will have them as a member.)
- "The CCFMC reviews are unfair, unnecessary, and time consuming. Why hasn't ISMS changed the PRO contractor?" ISMS does not appoint PRO contractors, the federal government does. On your behalf, ISMS has worked with HCFA in Washington, D.C. and Chicago to rectify some of the problems in CCFMC reviews.
- "ISMS supported a self-referral bill against its members' interests." That bill was introduced by the American College of Radiology. ISMS was successful in amending those bills so they are not unfair to physicians or patients.
- "The AMA joined the feds in pushing OSHA regulations on physicians." AMA had little input into current OSHA regulations regarding bloodborne pathogens and is working to fix the problems these regulations cause.
- "ISMS is against universal health programs." ISMS is for universal health access for all people, but against giving more control

to the same government that runs Medicare and Medicaid.

- "The AMA used my dues dollars to campaign against international medical graduates (IMGs) when I was a member."

AMA has bent over backwards to create — and listen to the recommendations made by — its advisory committee of IMGs. AMA has involved itself in multiple issues of importance to IMGs recently.

- "The AMA gave away the store to bureaucrats and insurance companies."

A weaker AMA would make the situation worse. A strong and unified profession at the county, state and national levels remains our best hope.

- "ISMS can't even make Public Aid pay my bills on time."

ISMS acts at every possible level to minimize the impact of budgetary problems on public aid reimbursement to physicians. ISMS Board Chairman Jere E. Freidheim, M.D., recently wrote to the state comptroller asking for her help in shortening the payment cycle.

- "An AMA officer recently said that HMOs save money. That is the biggest lie I've ever heard."

Our strength lies in our ability to maintain a unified profession. Many of our members in good standing participate in alternative health care plans, including HMOs. We must hold HMOs accountable to the highest quality of medical care, just as we do other health care delivery systems.

- "What about caps — why won't ISMS try any more?"

Malpractice caps remain high on the society's agenda. That is, as soon as we can count the votes in Springfield! Make sure you vote Nov. 3!

- "The AMA even supported the National Practitioner Data Bank."

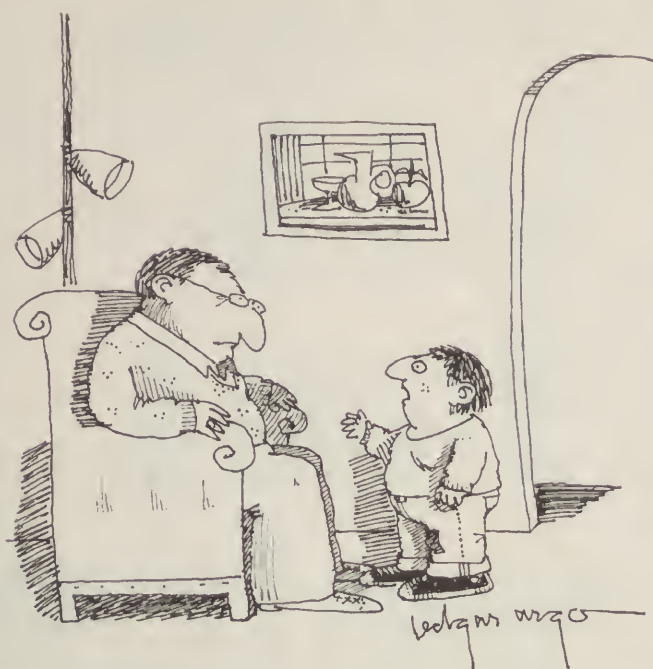
The ISMS House in 1991 supported dismantling the Data Bank. The AMA conditionally adopted that policy, if Data Bank problems cannot be rectified.

- "How come ISMS is quiet on prescription drug costs?"

See the President's Column in *Illinois Medicine* date September 25, 1992, "Out of Sight, Out of Mind."

Since you elected me your president, I have witnessed the work of your society firsthand and often. I am pleased to report that your state medical society remains a strong advocate for your practices and patients. "Being powerful is like being a lady or gentleman," I read somewhere. "If you have to tell people you are, you aren't."





"I think I understand everything, dad ... but how does the bee put on a condom?"

### GUEST EDITORIAL

## Osteopathic medicine: A century of making a difference

One hundred years ago this month, the first students walked through the doors of the American School of Osteopathy in Kirksville, Mo., establishing what is now the osteopathic medical profession.

When those students graduated, they took with them many of the principles that are still honored and used by contemporary doctors of osteopathy. DOs still look beyond the immediate health problem to determine the underlying causes and effects of injuries and diseases. They realize that today, as in the 19th century, muscles, nerves, tendons, organs and bones are all interrelated, one affecting the other. Osteopathic physicians have consistently advocated preventive measures, such as regular exercise and good nutrition, as ways to live a long and healthy life. But perhaps most important, osteopathic physicians have not forgotten that providing compassionate health care is still based on a one-to-one relationship that cultivates trust and honesty.

To celebrate its 100th anniversary and underscore its commitment to these principles, the American Osteopathic Association dispatched two mobile medical vans, dubbed Care-A-Vans, to provide basic health care screening in areas of the country that desperately lack medical attention. These vans were staffed by volunteer osteopathic physicians, medical students, interns and auxiliary members.

In Illinois, a Care-A-Van screened hundreds of people in Peoria, Bloomington and several underserved areas in Chicago, including a Chicago public housing complex on the city's Southwest Side and a Hispanic ministry on

the Northwest Side. All told, the Care-A-Vans accumulated more than 50,000 miles, visited 200 towns and cities, and screened more than 16,000 people.

This commitment of time and resources fits with osteopathic physicians' focus on serving in both rural and urban areas that are medically underserved.

In fact, although osteopathic physicians make up only 5 percent of all physicians, they constitute 15 percent of all doctors in towns with fewer than 10,000 people.

These screenings also emphasize DOs' commitment to serving in primary care areas. Currently 60 percent of osteopathic physicians practice in obstetrics and gynecology, internal medicine, pediatrics and general practice.

At a time when access to health care for some is restricted by socioeconomic factors, the Care-A-Vans provided health care screening to those who most needed it.

Additionally, the volunteers collected data that will be forwarded to federal health policymakers. The osteopathic profession hopes that a more comprehensive picture of the medically underserved population will emerge when the results are compiled.

The osteopathic medical profession sees the Care-A-Vans as one way to ease the problems of the medically underserved. During its 100th anniversary, the osteopathic profession urges all Americans to share the goal of ensuring that every citizen receives adequate health care, delivered by a trained medical professional in a compassionate and trustworthy manner.

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**Dennis Palmer, D.O.,** of Aledo, is president of the Illinois Association of Osteopathic Physicians and Surgeons.

## LETTERS

### An opinion on second opinions

ISMIE Update's "Case in Point" in the Sept. 25 issue reviewed three spine surgery malpractice cases and concluded with a series of recommendations by neurosurgeon Dr. Luis Yarzagaray as to how to minimize liability. Unfortunately, important steps in good patient care, which also operate to minimize or even remove liability, had been overlooked.

Good medical practice and fairness to the patient require that second opinions be obtained when there is no documented or provable pathology, when test results are questionable, or when myelogram, MRI or CT scan results are negative, unclear or unusual, but surgery still seems reasonably indicated. Have the myelogram, MRI or CT scan reviewed by a neuroradiologist and get a second opinion before scheduling surgery. (My own spine MRI was misread by an excellent hospital radiologist whose error was discovered and corrected by a neuroradiologist.) Not only will this produce the best patient care, but it will also eliminate or reduce any likelihood of being held liable for unnecessary surgery.

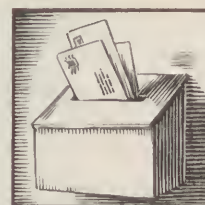
— Theodore Shelly Ashbell, M.D., J.D.  
Chicago

### Kudos on election coverage

I must commend *Illinois Medicine's* emphasis and coverage of the election process. Now that we've been supplied with all this wonderful information, we should act on it and vote!

Each year more health care decisions are being made by non-physicians in elected office, and it is our responsibility to ensure that these non-physicians are patient advocates. The Illinois State Medical Society Auxiliary and the county medical society auxiliaries recognize the significance of this election period. They are responding by hosting fundraisers for candidates, sponsoring voter registration drives and actively participating in political campaigns.

Election Day is your opportunity to secure responsible and receptive government for health care. Illinois citizens elect more than 40,000 public officials in more than 6,000 units of local government — more than any other state. Those we elect to represent us at all levels of government will most likely be incumbents for the next decade, and will continue to shape and influence health care policy and law. As a citizen and member of the medical community, you are responsible to exercise your right to be heard by voting for the candidate of your choice. Please be an informed voter and study the issues to learn which candidates support a sound and prosperous policy for the future. All you have to do is read it here in



*Illinois Medicine!*

Take part in shaping health care's future for the next decade by casting your ballot on Tuesday, Nov. 3.

— Pam Taylor  
ISMSA Legislative Chairman  
Springfield

### U.S. Senate candidate speaks out on reform

I and my campaign have been done a serious disservice by your Sept. 11 report on health policy positions. At no time was a request made of me — by phone, letter or fax — to provide you with an issue paper on health care concerns. No person on my staff can find a request directed to anyone else. Had such a request been made, we would have gladly responded, insofar as health care reform is a major concern in Illinois and in the nation.

I support a modified single-payer, universal system of health insurance that will allow every American access to health services. If we fund health care through a single-payer system, we can recapture the administrative waste associated with the current chaos and at the same time achieve economies of scale and cost control. Such a single-payer system will in most instances provide cost savings to business and will allow for the "decoupling" of health insurance from employment status. In most instances, the substituted payroll tax will be less costly than the insurance premiums currently paid by American business and workers.

Quality of service and freedom to choose a provider are important values that can be preserved if the service delivery aspect of the system is administered locally, on a state-by-state basis. In that way, decision makers who determine rates and allocation of services are kept directly accountable to their own communities.

In short, I would like to see the insurance and care components of a universal system of health care treated as distinct elements of a single issue. If we think globally about the funding of health care but act locally in the delivery of services, we can achieve the kind of reform that will give us the best health care system in the world.

— Carol Moseley Braun  
Chicago

*Editor's note: Illinois Medicine contacted Braun's office several times between Aug. 20 and Aug. 28. On Aug. 20, our reporter asked David Eichenbaum, Braun's campaign press secretary, for an interview or a written statement explaining the candidate's views. Eichenbaum agreed to respond by the Aug. 26 deadline, but several follow-up phone calls to him were not returned.*





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--Harold L. Jensen, M.D.  
Chairman, ISMIE Board of Governors

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*Case in Point  
explores  
failure to  
diagnose MIs*  
PAGE 10

# ISMIE Update

## MALPRACTICE ROUNDUP

PAGE 10

## Exchange rates determined by loss experience of specialties, territories

**PREMIUMS:** Each year the Exchange calculates new premiums based on loss trends. By Anna Brown

[ CHICAGO ] Last April, the Illinois State Medical Inter-Insurance Exchange announced there would be no change in the base premium rate for the 1992-93 policy year. In addition, many policyholders reaped the benefit of premium reductions when their specialties moved into lower classes or when some territory rates were lowered. Still others found themselves paying more this year when their specialty rates were increased.

Such fluctuations aren't haphazard, said Harold L. Jensen, M.D., chairman of the Exchange Board of Governors. They are based on loss experience trends over a period of at least three years.

"The Exchange salutes physicians in those specialties and counties who improved their loss experience," Dr. Jensen said. "Even though in the past year there has been a significant increase in both frequency and severity of losses, in many cases we were able to offset those

activities for our policyholders. "In 1992, we were able to introduce a new feature to the Exchange rate structure," Dr. Jensen added. "We rewarded policyholders who had been loss-free with a discount on pre-

*"Even though in the past year there has been a significant increase in both frequency and severity of losses, in many cases we were able to offset those."*

HAROLD L. JENSEN, M.D.

miums. Since the Exchange's inception, we have sought fairness in rate setting - having each policyholder pay according to the risk he or she brings to the company. The loss-free

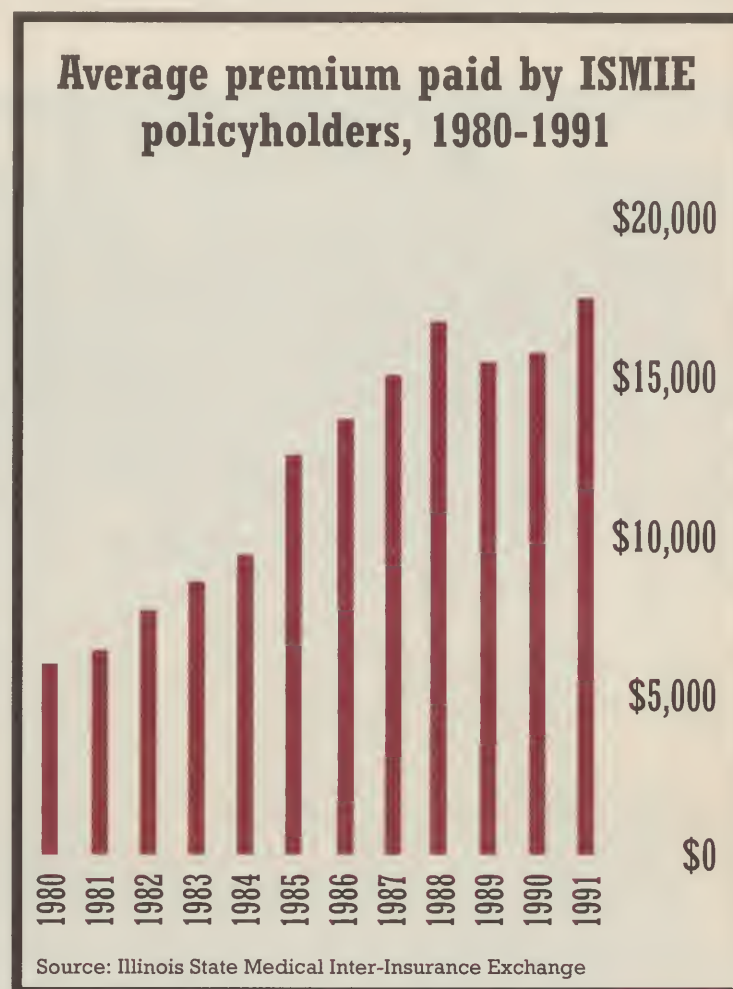
discount was a further refinement of this philosophy."

New rates are determined through close examination of loss trends, said Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors. "We look at the past to help us predict the future," he said.

The Exchange contracts with two actuarial firms for two perspectives on what rates should be, Dr. Boren said. Both firms provide the Exchange with policy rate information from insurance companies nationwide. Losses from indemnity payments and expenses are tabulated each year to establish trends; base premiums and rates within specialties and territories are determined from these.

**OVERALL, BASE RATES** are determined from data based on five factors: the cost of settlement, the cost of defense, payout patterns, reporting patterns and portfolio returns, he said.

The most common decrease in premiums is caused by good loss experience within specialties and territories, Dr. Boren



said. Specialties are divided into classes numbered from zero to seven, with the lowest classes paying the least premium. Actuaries determine relative ratings for each class, based on the entire loss history for that specialty.

Similar relativity ratings are applied to counties to determine territory rates. Counties are divided into four territories: Territory I, including Cook, Madison, McHenry, St. Clair and Will counties; Territory IA, including DuPage, Kane, Lake and Vermilion counties; Territory II, including Champaign, Jackson, Macon and Sangamon counties; and Territory III, which includes the rest of Illinois.

For specialties to lower their class or counties to reduce their territory, they must show significantly improved loss experience over a period of three years, Dr. Boren said. "Everybody is going to have a bad year occasionally. Three years give the Exchange and the policyholder confidence that a loss trend will continue."

Dr. Boren said the three-year

rule also protects the policyholder in cases in which a specialty experiences particularly heavy losses during one policy year.

**TWO OTHER SIGNIFICANT** factors affecting rates are reporting patterns and payout patterns. Both affect long-term funding plans, since reporting and payout only rarely occur during the year of loss. "When an incident occurs in 1992, it may not be reported for three to four years," Dr. Boren said. "Similarly, the Exchange will not pay out on all cases that occur in 1992 for 15 years or more, although the bulk of payments are usually made between six and nine years."

A claims-made policy is priced so that the policyholder pays yearly for protection against claims that may be reported during that year - a pay-as-you-go system, Dr. Boren said. The first year's premium is lower than subsequent premiums because of the low probability that a claim resulting from treatment provided

(Continued on page 26)

## EXCHANGE Q & A

**Q. Which of the Exchange's liability limits is best for me?**

A. Physicians can choose from a variety of limits up to \$2 million per claim/\$4 million aggregate per year. The limits for adequate protection vary by practice specialty, location and setting. Hospital requirements for medical staff privileges usually establish a minimum liability limit. All employees within a group practice should carry equal

limits. Keep in mind that if the amount of insurance chosen does not cover all of the claims reported during the year, personal assets can be at risk.

**Q. If I am sued for malpractice, who will defend me?**

A. The Exchange works with a select group of defense attorneys experienced in medical professional liability litigation. If a defense attorney is

necessary, the Exchange will assign one to represent you.

The primary defense team consists of the defendant-physician, the defense attorney and the Exchange professional liability analyst, who coordinates the case. All three work together under the Exchange's aggressive defense policy. You will be actively involved in evaluating the medical aspects of the case and planning your defense. ■



## Case in Point

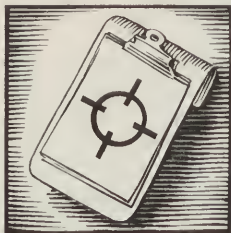
By Tony Sullivan

A regular feature using hypothetical case histories to illustrate loss-prevention maxims.

### Case #1

**Presenting complaint and initial diagnosis:** A 50-year-old man with a history of chronic hypertension visited his primary care physician for

a regular checkup in early May. All vital signs were normal, but the patient complained of nasal bleeding and shoulder pain. He had been receiving treatment for the shoulder problem, which was diagnosed as osteoarthritis, for nearly four years. The physician treated the shoulder with hydrocortisone and lidocaine hydrochloride and prescribed Biflavonol, an over-the-counter food supplement, for the nasal bleeding.



**The case in brief:** The patient was overweight and smoked about one pack of cigarettes a day. He had been treated for

hypertension for nearly 10 years by a physician who prescribed ester hydrochloride, an anti-hypertensive medication, in various doses and frequencies. At certain office visits, the physician also had noted an enlarged heart and periodic murmurs. Despite these clinical, social and behavioral facts, the physician never performed a complete cardiac work-up on the patient and never documented a thorough clinical, family and social history.

Two days after the May office visit, the patient returned to the physician's office. While a nurse was taking his blood pressure, the man suffered an acute myocardial infarction and died.

**The resulting claim:** The decedent's wife sued the primary care physician for failure to diagnose a myocardial infarction, alleging that the patient should have been hospitalized after the initial May office visit.

**The outcome of the claim:** The case was settled for \$313,000.

### Case #2

**Presenting complaint and initial diagnosis:** A 37-year-old man awoke one night with chest pain and nausea. Two hours later, he went to the hospital emergency room and was admitted to the coronary

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

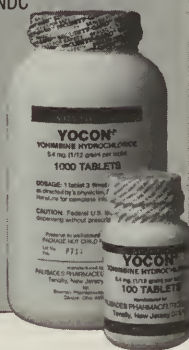
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological Basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## MALPRACTICE ROUNDUP

### Rural maternity program successful

A University of North Carolina-Chapel Hill study reports North Carolina's Rural Obstetrical Care Incentive Program has been successful in preserving maternity care networks. As reported in the *Raleigh News-Observer*, participation in the three-year-old program has increased from 52 doctors in 21 counties in 1989 to 177 doctors and 13 midwives in 59 counties today. The program pays a maximum of \$6,500 in malpractice insurance for its doctors and \$3,000 for midwives who work in rural areas.

North Carolina still has 24 counties where no one is willing to deliver babies. In addition, there are 33 counties where no doctor will deliver the babies of women on Medicaid, and last year two out of five births were under Medicaid. Donald H. Taylor, the study's chief author, said it is not enough to get someone to move to North Carolina and set up practice; rather, the program is an attempt to "shore up" the people who are already there.

### U.S. Supreme Court upholds Florida's medmal law

United Press International reports the Supreme Court Oct. 5 upheld a 1988 Florida law requiring doctors not involved in childbirth to pay a \$250-per-year tax to help fund affordable malpractice insurance for obstetricians. The tax was enacted to deal with a dramatic rise in malpractice insurance rates, which hits doctors involved in childbirth the hardest. Between 1972 and 1987, the amount of money Florida obstetricians and gynecologists spent on malpractice insurance increased from an average of about 4.2 percent of their annual gross revenues to more than 23 percent.

Part of the Florida Birth-Related Neurological Injury Compensation Plan includes immunity from malpractice for participating obstetricians involved in certain procedures. Any obstetrician in the state who wishes to buy the insurance is charged \$5,000 annually; other licensed physicians in Florida — who are not eligible to take part in the health insurance plan — are charged \$250 per year. A group of doctors who are not obstetricians filed suit claiming that the tax violated their 14th Amendment guarantee of equal protection under the law.

### More malpractice suits naming HMOs

According to the Physician Insurers Association of America, managed care organizations and medical malpractice insurance companies should become partners in the tort reform effort. Larry Thrower, chief operating officer of COPIC Insurance Co., a physician-owned medical malpractice insurance company in Englewood, Colo., told the PIAA annual meeting that more medical malpractice suits are naming HMOs as defendants.

By working together, the managed care industry and physicians' insurers can reduce their exposure to malpractice lawsuits and their outlays for defense costs, the PIAA determined. Medical professional liability insurers should also continue looking for ways to work with managed care organizations to develop a common defense in lawsuits.

Thrower said the two groups must resolve several areas of conflict, including cost containment vs. standard of care. "But," said Thrower, "these are things that we can work our way through. We need to join in partnership with the emerging types of health care delivery systems that will be prevalent in this decade and into the next century."

### Award to comatose patient

*New Jersey Medicine* reports that a New York court decided a jury had the right to award pain and suffering damages to a comatose patient. The decision came after experts determined that a comatose patient was unaware of pain when he died after 40 days in a coma.

In deciding that a jury could overrule expert testimony the judge declared, "Lay opinion may compete with medical opinions where the issue relates to matters cognizable by either."



care unit through a telephone order by the on-call physician covering for the patient's regular physician. An electrocardiogram performed by a consulting cardiologist indicated an acute MI.

**The case in brief:** The patient remained stable for several hours until he experienced an episode of sudden precipitous ventricular fibrillation and died.

Four months prior to being admitted, the patient complained to his doctor of coughing and shortness of breath, which worsened on exertion. An examination revealed congested lungs, and the physician prescribed a multi-vitamin and ampicillin for a suspected viral infection, but did not perform an EKG.

The decedent was overweight and a one-pack-a-day smoker. His medical records lacked a detailed clinical, family and social history, including the facts that he smoked and that his family had a strong history of heart problems.

**The resulting claim:** The patient's family sued the primary care and on-call physicians for failure to diagnose and treat an MI.

**The outcome of the claim:** The case was settled for \$308,000.

**The points these cases make:** Both cases underscore the need to conduct and document a thorough clinical, family and social history on every patient, said Dan Fintel, M.D., a cardiologist who directs the coronary care unit at Northwestern Memorial Hospital in Chicago. "About 80 percent of all cardiac diagnoses are obtained from a careful history," he said.

A thorough history also would have identified that the patients in both cases had multiple risk factors for a cardiac event, said Patrick Scanlon, M.D., chief of cardiology at Loyola University Medical Center and professor of medicine at Loyola University's Stritch School of Medicine. In Case No. 1, the patient was in the cardiac-prone age group, obese, male, and a smoker. In Case No. 2, the patient had nearly identical characteristics plus a telltale family history of cardiac problems. This information would have raised the level of suspicion that the patients' presenting symptoms may have been tied to cardiac trouble, he said.

Neither patient in the cases presented had a timely EKG performed before his MI. Considering the patients' histories, the treating physicians in each case erred by not performing an EKG at some point during the course of treatment, Drs. Scanlon and Fintel agreed. A history of hypertension doesn't indicate the need for an EKG with each office visit, according to Dr. Fintel. "But when you know the man is already hypertensive, it would be relevant to obtain EKGs to follow the progression of left ventricular hypertrophy. It would allow for the physician to determine if there are any new changes, such as a new MI, which we know can occur in such an individual."

MI's can be difficult to diagnose because many are "silent," and many symptoms are masked by other symptoms that appear to be unrelated to the heart. About one-third of all MI's remain undiagnosed until a screening electrocardiogram is performed, Dr. Fintel explained. Some of these silent MI's are heralded by symptoms that the patient

attributes to something else, such as indigestion, musculoskeletal pain or flu. These are important symptoms to watch for because they may indicate cardiac problems, Dr. Fintel said.

Other symptoms include a new onset of chest discomfort, shortness of breath, and/or a tightness, heaviness or squeezing sensation in the chest, Dr. Scanlon noted. The discomfort may appear in the chest, neck, throat, teeth or jaw.

If patients' presenting symptoms suggest ischemia, physicians should admit them into a facility where they can be monitored early and properly, Dr. Scanlon stressed. Patients should be admitted

when they experience a change in symptoms, such as new pain, or pain that's worse than or different from the previous pain. Physicians also should consider admitting patients presenting with symptoms such as dyspnea, Dr. Scanlon suggested.

Because MI is such a potentially disastrous condition, physicians should err on the side of caution, Dr. Scanlon said. "Even though we're trying to keep costs down, in these cases neither patients nor the system is well-served to worry about costs vs. the threat of loss of life."

The main problems with the two cases stem from failing to elicit a thorough

medical history, both physicians agreed. "A thorough history that costs nothing other than several more minutes of a physician's time can often establish a diagnosis of cardiac disease more frequently than all of the invasive and non-invasive tests [can]," Dr. Fintel said. "A careful history and the documentation in the doctor's notes that the history was elicited can go a long way toward minimizing the risk of being sued for malpractice and, more importantly, protecting the patient against a missed diagnosis." ■



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# Pre-election coverage concludes with nine key House races

*Illinois Medicine* concludes its 1992 pre-election coverage with candidate profiles in nine key Illinois House districts.

85<sup>th</sup>  
DISTRICT



## Bruce Clark – Republican

As Kankakee County clerk, Bruce Clark serves on the board of the Illinois Association of County Clerks and Recorders. He also serves on the boards of directors for the United Way of Kankakee County and Kiwanis. Clark earned a bachelor's degree in political science from the University of Kentucky.

"Our health care system is the best in the world," Clark said. "It's not health care that needs reform, but health care costs that must be addressed."

Clark believes the federal government should institute reform. He said "significant population centers" on Illinois state borders could cause people from other states to overburden a state-run system. "We must make changes across the nation, not just in specific states," he said.

Clark opposes a single-payer, government-run health care system because he believes in individual choice, he said. "The Canadian system is experiencing some major funding problems," he said.

"The fastest rising cost in the health care industry is the spiraling cost of liability," Clark said. "If we truly want to reform our health care system, we have to pass tort reform legislation. I support a \$250,000 cap [on noneconomic damages in malpractice awards]. Tort reform must be the first step we take to ease the health care cost crunch."



## J. Philip Novak (I) – Democrat

J. Philip Novak, 86th District representative since 1987, has served on the Agriculture, Education Appropriations, Environment and Energy, and Veterans Affairs committees, and was vice chairman of the Committee on Conservation Law. He earned a B.S. in education and an M.A. in political science from Eastern Illinois University and served in the U.S. Army in the Panama Canal Zone.

Novak does not support a single-payer national health system and voted against the Illinois universal health bill, H.B. 2774. He said the bill would have created "prohibitive taxes" and bureaucracy.

Novak told *Illinois Medicine* reform should come at the national level, and should include standardizing insurance claim forms and requiring coverage for pre-existing conditions to help make health care accessible to all. Rep. Novak praised the idea of forming a blue ribbon panel of experts to study health care reform. "The health care industry should be brought together – including physicians, hospitals, nursing homes and pharmaceuticals – to determine how to manage costs," he said, adding that physicians should be reimbursed at reasonable rates.

"People in Illinois don't want their taxes raised, but we have increasingly more demands on the system," Novak said. "Small employers can't provide insurance, so we must provide incentives for them to do so." He said he foresees the medical industry's move toward managed care and would support a negotiated bidding process to set rates.

Novak supports caps on noneconomic damages in malpractice suits but is unsure what amount should be set. "These high awards for noneconomic damages are preposterous," he said.



## Dan Rutherford – Republican

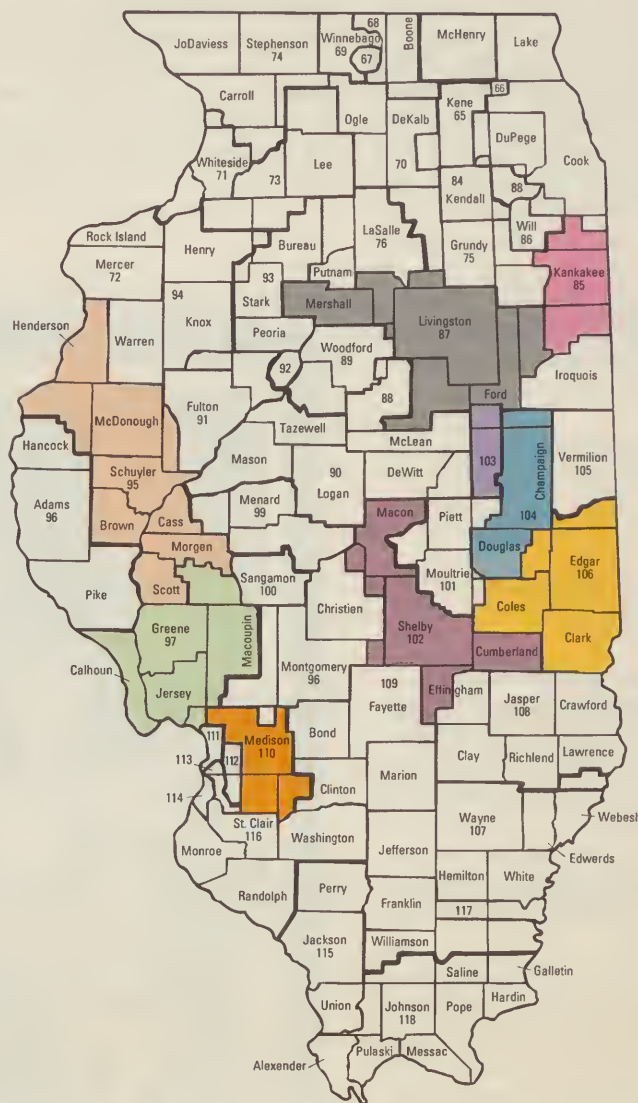
Dan Rutherford, of Pontiac, is a vice president of ServiceMaster Co. in Downers Grove. He is also a member of the Livingston County Farm Bureau, the Illinois Corn Growers Association and the Livingston County Council for Economic Development. Rutherford graduated from Illinois State University in 1978, with a degree in business administration.

Rutherford opposes a single-payer, government-run health care system, saying that the tax increases needed to cover such a program would be "devastating to the state." He said reform should come on a national level; the state can do a certain amount, but overall the nation must address health care issues.

Rutherford outlined several ways the state could institute reform, such as implementing caps on noneconomic damage awards in malpractice suits. "We've gotten to be an overly litigious society, which has really driven up health care costs," he said. He also advocates "streamlining" insurance forms.

"Overall, we need to bring together health care providers – doctors,

## Selected Illinois House Districts



Source: Illinois State Board of Elections

87<sup>th</sup>  
DISTRICT



## Chuck Rolinski – Democrat

Chuck Rolinski, a teacher and athletic director at Toluca High School for 34 years, is Toluca city treasurer. He received bachelor's and master's degrees from Illinois State University under the GI Bill, and is a Korean War Army veteran. He has been active in community sports and organizations, and is a member of the Illinois Basketball Coaches Hall of Fame, the Toluca Businessmen's Association and the

Knights of Columbus.

Rolinski supports the Illinois Health Care Reform Task Force created under the Medicaid Revenue Act. He said the task force is responsible "for the development of long-term strategies for controlling rising health care costs [and for] exploring the need for changes to the design of the current service delivery systems and the manner in which health care is provided to Illinois citizens."

"The task force must develop recommendations for restructuring the Illinois Medicaid program," Rolinski said.

He opposes the new Medicaid provider tax on hospital and nursing homes, calling it an "unfair and inequitable method of paying for the escalating costs of medical care for the poor."

"Effective, universal cost controls need to be implemented," Rolinski said. "States, however, cannot independently afford to cover the increasing Medicaid burden. The federal government must provide some relief. I would urge the president and the U.S. Congress to reorganize the system so that private and nursing home patients won't have to continue paying a disproportionate share of the cost."

87<sup>th</sup>  
DISTRICT



## 95th DISTRICT

**DeWayne Bond – Republican**

DeWayne Bond has been sheriff of Schuyler County since 1982. He grew up in East St. Louis, worked on his father's farm on the Mississippi River and received a degree in industrial technology from the University of Houston.

Bond is "at complete odds" with the notion of a single-payer, government-run health care system, said his spokesman Jason Christensen. Bond believes reform should come on the national level; however, the "state wouldn't be a bad starting point," he said.

His main concern about a Canadian-style health service is that rationing would "kill rural hospitals. Beardstown hospital shut down, and it [has] been very tough on the community," Christensen said. Bond also fears that people from other states would strain a state-run health care system.

Bond would support tort reform to lower malpractice insurance premiums, Christensen said. He also advocates a \$250,000 cap on noneconomic awards in malpractice suits.

Christensen said Bond wants to "keep the medical profession worth going into."

**Bill Edley (I) – Democrat**

Rep. Edley did not respond to several interview requests.

## 97th DISTRICT

**Tom Ryder (I) – Republican**

An attorney from Jerseyville, Rep. Tom Ryder has served the 97th District since 1983. He has been assistant minority leader, and has served on the Health Care, Insurance, and Labor and Commerce committees, and was spokesman for the Human Services Appropriations and Public Safety and Infrastructure Appropriations committees. He graduated from Northern Illinois University and earned his J.D. from Washington and Lee University in Lexington, Va.

"Medical malpractice insurance and extra tests doctors must conduct are major reasons for health care cost increases," Ryder told *Illinois Medicine*. He said such costs could be curbed by instituting several changes, including a cap on noneconomic awards in malpractice suits. "I have supported caps before and will continue to do so," he said.

Although he believes changes need to be made in the current health care system, Rep. Ryder said he does not believe a universal health care system would be the answer. "The states should be allowed flexibility," he said, adding that the federal government is "incapable of making decisions."

"I would like to see Illinois moving toward a plan similar to the Oregon plan," he said.

Ryder said the state cannot afford unlimited care for Medicaid patients, and "intelligent choices on rationing need to be made."

He emphasized his concern over the "huge administrative overhead" of managed care and insurance coverage, and advocated standardized insurance forms to reduce the time and expense physicians spend in filling out forms.

**Henry G. Jackson Jr. – Democrat**

Henry G. Jackson Jr. did not respond to several interview requests.

**N. Duane Noland (I) – Republican**

Rep. N. Duane Noland of Blue Mound is a one-term representative for the 102nd House District. He provided *Illinois Medicine* with the following written statement:

"The health care system of the United States is arguably the best in the world. Before we dismantle our current system and hand over responsibility to our government, I would endorse market reforms.

Access to health insurance must be improved, and the rising costs of health care must be curbed. This could be accomplished through reforms to our present tax system, to provide tax subsidies for health insurance and to create medical care savings accounts.

"A national health care system would likely mean a decrease in access to services, lack of choice for consumers, waiting lists and limited availability of technology to control costs. It would be a financial disaster for our state to implement such a plan without national support.

"The Medicaid funding crisis in our state is an embarrassment and a major factor attributing to escalating medical costs. This problem can be dealt with on a long-term basis through prioritized government spending and economic recovery.

## 102nd DISTRICT

"Everyone pays for costly malpractice suits, and we must control stratospheric monetary awards for damages. I support caps on noneconomic damages but have not determined a fair dollar limit."

**Doug Wolfe – Democrat**

Doug Wolfe covered the Illinois Statehouse for WAND-TV in Decatur for 12 years. He resigned his reporter's job in November 1991 to run for the General Assembly.

"I generally support the single-payer idea," Wolfe told *Illinois Medicine*. "First, I think we should go with a national health care system as our first alternative, preferably the one being supported by presidential candidate Bill Clinton. I believe such a national plan should, however, have local control, where [people] are allowed to choose [their] own doctors, hospitals and health care providers. I think it is paramount for the state to step forward and pass its own plan if the national plan does not go through."

While opposing any tax increases, Wolfe called for immediate bipartisan action on solving the Medicare-Medicaid funding crisis. "I think it's going to take a bipartisan solution. It took Republicans and Democrats to get us into the situation we're in now; I believe it's going to take a bipartisan Republican-Democrat effort to get us out."

Wolfe opposes tort reform measures. "Generally, I believe tort reform has not worked in other states. I believe tort reform and caps simply hurt the consumer. There are a few – very few – doctors who are guilty of malpractice, but I believe the ones who are guilty should have to pay for their errors. I don't believe we should penalize consumers by [enacting] restrictive laws that limit the amounts they are able to recover."

## 103rd DISTRICT

**Gregory D. Cozad – Republican**

Gregory D. Cozad, a Champaign attorney, served on the Champaign City Council from 1987-91. He chaired the Champaign Development Services Task Force and was on the Board of Directors of the Urbana-Champaign Economic Development Corp. from 1987-91.

"We need to build on the strengths of the current system and make reforms in the areas where we have weaknesses," Cozad told *Illinois Medicine*. "We need reforms in the insurance area [and] in the medical malpractice area, and better consumer education."

Cozad opposes a single-payer, government-run health care delivery system. "First, I don't like the idea of an entirely government-run system, and second, it would have a tremendously negative impact on our state budget. It would triple the state payroll tax, and there would be a variety of fees and taxes that would be [enacted]." Cozad also said that enacting a Canadian-style system might cause small businesses to move out of state, while indigent people might move into Illinois to "get their so-called free health coverage."

Cozad advocates such insurance industry reforms as standardized forms, coverage of pre-existing conditions and expansion of risk pools "so that more people can be covered." He supports a \$250,000 cap on noneconomic damages in medical malpractice cases.

**Laurel Lunt Prussing – Democrat**

Laurel Lunt Prussing, an economist from Urbana, served on the Champaign County Board from 1972-76 and as county auditor from 1984-91.

"I favor the universal health care [approach] that is used in all countries except the United States and South Africa," Prussing told *Illinois Medicine*. "I think the Canadian system seems to be a good model, although I would be willing to consider something like the Hawaiian system." She said that both systems – the single-payer Canadian system and the dual-payer Hawaiian system – have significantly reduced administrative costs. "I think that we are not spending our money wisely. We have gotten to the point where we are spending more on health care than on defense and public education combined. I think it is an intolerable situation."

Prussing would address the Medicare and Medicaid funding crisis through expanded sales taxes on personal care services, such as beauty shops, dry cleaners and video rentals.

Prussing said she would consider a cap on noneconomic damages "if there were caps on physicians' fees. [To argue] that lawyers' fees should be limited and physicians' fees should not put you in kind of a weak position." Citing a July 1992 report in *Consumer Reports*, she also said the impact of medical malpractice costs has been exaggerated. "I think there is a problem, [but] there is an even bigger problem with people who don't even file claims and are injured by bad medical practice."

## 102nd DISTRICT

# VOTE NOV. 3



## 104th DISTRICT

**Timothy V. "Tim" Johnson (I) – Republican**

Rep. Timothy V. "Tim" Johnson, an assistant minority leader, currently represents the 104th House District. A member of the House since 1977, he is being challenged by 103rd House District Rep. Helen F. Satterthwaite. Johnson provided *Illinois Medicine* with the following statement:

"There is no question that the current health care system in this state – in this nation – is in need of repair. Of all of the reform proposals out there, however, I do not believe that a single-payer, government-run program is an appropriate alternative for the people of Illinois. Any type of reform should be based on the concept of a free market and competition starting with a change in the way insurance companies provide coverage to individuals.

"This repair needs to start on the federal level, though. The federal government is in a unique position to take action immediately and can do so by taking a look at and possibly restructuring insurance programs like Medicare and government programs such as Medicaid. The states can then make the fitting adjustments based on the federal efforts and that state's individual needs.

"I am also concerned with the current tort situation. I would support suitable and reasonable changes in our tort system where either side, plaintiff or defense, could substantiate any unfairness to the delivery of justice."

**Helen F. Satterthwaite (I) – Democrat**

Rep. Helen F. Satterthwaite, an assistant majority leader, currently represents the 103rd House District and has been a member of the General Assembly since 1975. As a result of redistricting, she is running against 104th District incumbent Timothy V. "Tim" Johnson.

Satterthwaite leans to a single-payer, government-run system. "I think that just from what I've been able to observe, a single-payer program is probably better, but I am willing to stay open-minded in regard to other types of payment systems," Satterthwaite told *Illinois Medicine*. "I think that ultimately we need some kind of access assurance at the federal level, but I am willing to support something at the state level if the federal action doesn't take place pretty soon."

Absent conversion to a single-payer system, Satterthwaite said that the current hospital and nursing home assessment program to capture federal matching dollars for Medicaid should be replaced and that the state needs to plan for increasing demands. "We are getting a much higher percentage of elderly, and in many of those cases, even if people saved money or had some reserves that they thought were going to take them through their later years, they're finding it's not meeting those needs and eventually they have to come onto Medicaid."

Satterthwaite said she wants more information on the fairness of current malpractice awards. "My impression is that even though you hear about these fairly large awards, most of them are appealed and whittled down, and I'm not sure how much the awards end up being. ... I need more information to know what the final awards actually are and whether those really look like they're out of line compared to the situation that generates them."

**Michael "Mike" Weaver (I) – Republican**

Michael L. "Mike" Weaver of Charleston has represented the 106th District since 1985.

Weaver said he is not prepared to vote for a single-payer, state-run health care system at this time because "it would be horribly expensive and would place us in the Midwest as being the drawing card for a lot of those who would want their medical expenses taken care of and would move here for that reason." He said the federal government needs to take the lead in health care reform to avoid a "patchwork quilt of medical services from state to state."

Weaver said although the government should provide basic medical services to Medicaid patients, the state needs to limit the number of available medical services. He mentioned the Oregon plan as an option for Illinois to consider. "In any case, what we're going to have to do is bureaucratically revise the Medicaid system [to] have some kind of payer contribution. It is absolutely essential in my mind to help us avoid abuse of the system, even it is only \$1 or \$2."

Weaver supports caps on noneconomic damages but thinks the oft-mentioned \$250,000 figure is politically unrealistic.

**Carolyn Brown Hodge – Democrat**

Carolyn Brown Hodge was a broadcast journalist for WPRS/WACF radio in Paris, where she resides with her husband and two children. She also served as executive coordinator of the Paris Bicentennial Art Center and Museum.

"The state's broke, and the health care system's broken," said Hodge, noting that the state's fiscal crisis and health care reform are intertwined.

"I think having an equal plan for every resident in the state of Illinois is what we've got to do," she said, adding that she favors a single-payer

health care delivery system. "It would be nice if all through the state, the businesses paid equally and the people paid equally and the plans never changed and the forms never changed. That in my estimation would work. It does not have to be government-run. It can be run by its own entity separate from the government, and that should be looked into."

Saying that waiting for the federal government to enact reform legislation is a "cop-out," Hodge added, "I am not afraid of Illinois' taking a stand. It would be fine for Illinois to take the leadership role and maybe set some standards for other states to follow."

Hodge supports income tax reform to plug the deficit hole created by underfunding of Medicaid. "I think it's time to look at a graduated income tax. It can be done without hurting the middle class, which is shrinking altogether, anyway."

Hodge does not support caps on noneconomic damages. "I believe each case is individual, just as each case when a person sees a physician is individual," she said. "I don't like the fact that people think that everyone is abusing the legal system, like they think people are abusing their physician. Individual doctors should treat patients individually, and our court system has to treat cases individually."

## 110th DISTRICT

**Ron Stephens – Republican**

Ron Stephens, a pharmacist from Troy, served in the Illinois General Assembly from 1984-90. For the past year he has served as director of Emergency Management Services for the state.

Stephens rejects both a national health care system and a state-run health care system.

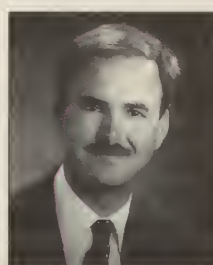
"The two are equally unacceptable," he said. "While I agree that reform is necessary, any change should be true reform – not a replacement of the current system."

Stephens cites tort reform and insurance reform as two important aspects of reducing health care costs. "We should start with caps on noneconomic losses, and I think we should consider placing limits on plaintiffs' attorneys' fees as well," he said.

Stephens also supports reforms to help reduce the number of frivolous malpractice suits. "I think we could consider having a losing plaintiff pay a fine, as well as being responsible for court costs and defense fees."

In the area of insurance reform, Stephens calls for standardization of claim forms as a way to save almost 7 percent of the nation's annual health care costs. Stephens favors "MediSave," promoted by U.S. Rep. Dennis Hastert (R-Batavia), which would allow families to "save up" deductibles not spent on medical care. "We shouldn't have the government telling us which hospital or which doctor we have to use," he said. "I would support reform that protects the integrity of the private system and allows the government to play a role in encouraging healthy behavior and savings."

Long-term adjustments to the public payment of health care also deserve consideration, he said. "I think it's ridiculous to try to balance the budget on the backs of the providers. If you made the members of the General Assembly the last ones to get paid – rather than the hospitals, the pharmacies and the doctors – you can bet we'd have a much better cash flow."

**Robert Daiber – Democrat**

Robert Daiber is a teacher and family farmer. He has been named "Teacher of the Year" by Triad High School and "Outstanding Teacher" by state and national teachers' organizations. He has published four books on education and holds a doctorate of education. Daiber provided the following statement to *Illinois Medicine*:

"I believe health care reform must come about as a cooperative effort between federal and state governments. Working class people need affordable health care more today than ever before. Individuals who have suffered from unemployment cannot afford today's medical costs.

"I support a health care plan [in which] each individual who participates will pay a fair premium. If a health care system is established, it must be universal across the country or great controversy will occur from state to state. I believe the most important part of a health care program is [giving] people ... the option to participate or seek private health care as they wish. I stress this option because such an option demonstrates democracy for citizens.

"To solve the funding crisis for Medicare and Medicaid will require a great deal of assessment of everyone involved in the system. The system has been abused, and the result is the lack of available money.

"I do not support caps on certain malpractice awards. I trust my doctor and would hope that others would do the same. Likewise, I am not convinced that caps would lower malpractice premiums."

Anna Brown, Kevin O'Brien and Ginny Thiersch contributed to the election coverage in this issue.

## 106th DISTRICT



# Immunizations aren't just for kids anymore

**IMMUNIZATIONS:** Because many adults are not receiving critical vaccines, illness and death often result. By Kathy Meyer

[ CHICAGO ] Immunizations are not just for children. They are critical for adults, too, but many adults are not being properly immunized, and the impact has been costly.

In all, upwards of 115,000 people may die each year from vaccine-preventable diseases. Of those, only 1,000 to 1,100 are children, suggesting that current adult immunization efforts are failing.

Adults should receive some or all of eight vaccines – influenza, pneumococcal polysaccharide, hepatitis B, measles, mumps, rubella, tetanus and diphtheria – depending on age, lifestyle, occupation, environmental situation and travel. (See chart below.) But many do not. According to the Illinois Department of Public Health, less than 5 percent of senior citizens recently surveyed had received a pneumococcal vaccine. The U.S. Centers for Disease Control estimates that more than 11 million childbearing-age women nationwide are not protected against rubella, more than 7 million young adults are not immune to measles and mumps, and more than half of all adults lack protection against tetanus and diphtheria.

"We're starting to see a large number of these cases [of vaccine-preventable diseases] in young adults and the older population," said Richard V. Galati, public health program administrator for IDPH. "We've done a real good job vaccinating those who are going to school, because it's mandated. But we often forget that adults need to be immunized too."

It's important to immunize adults to help close gaps in coverage, Galati told *Illinois Medicine*. Although hepatitis B immunization is now routine for infants, many adults may not be protected against the disease because the vaccine wasn't available until 1982. Many wom-

en of childbearing age lack protection from rubella, because immunization wasn't required for females 10 years or older in Illinois until 1987.

**ADDITIONAL GAPS EXIST** because some childhood vaccines don't provide life-long immunity. Immunity to tetanus and diphtheria is maintained only by following up the initial vaccine series with boosters every 10 years. Many adults may not receive these booster shots, Galati suspects, because they aren't required once they're out of school.

The impact of these gaps has been costly, in many respects. Influenza, the most widespread vaccine-preventable disease, typically causes more than 172,000 hospitalizations a year, costing \$600 million; a severe epidemic can cost as much as \$12 billion. It kills between 20,000 and 70,000 people a year, 80 to 90 percent of whom are over the age of 65.

**OF THE MANY FACTORS** contributing to the low adult immunization levels – the lack of public awareness of the benefits and the absence of an extensive delivery system – public health officials said the most important factor may be "missed opportunities" by health care providers during routine and emergency contacts in private offices, clinics and hospitals. In several studies, the CDC found that at least 75 percent of the people at high risk for influenza had received outpatient care but not a vaccine. At least two-thirds of pneumococcal patients had been hospitalized once within three to five years of their illness but had not been immunized.

"In some circumstances where patients are seen for annual colon cancer screenings, for example, sure there are missed opportunities," said Joan E. Cummings,

M.D. An Illinois State Medical Society Trustee, Dr. Cummings, director of the Edward A. Hines Jr. VA Hospital in Hines, specializes in internal medicine and gerontology. "There has been a mild resurgence of tetanus recently, so we've added that [immunization] to the routine care given patients in our geriatric clinic."

*"Whether to vaccinate is a question of what is critical. Prevention often is not deemed critical, particularly in a difficult economy."*

**BOB HOWARD,  
CDC SPOKESPERSON**

Although it is unclear why some health care providers are lax in vaccinating adults, federal and state public health officials speculate that many doctors don't know all the indications for a particular vaccine. In one physician survey, the CDC found that more than 50 percent routinely immunized patients with cardiopulmonary diseases against the indicated illnesses, but failed to consistently immunize patients with other risk factors, such as occupational exposure to bloodborne pathogens.

The American College of Physicians publishes detailed guidelines for adult immunization. The "Guide to Adult Immunizations" is available to physicians – for \$13 (members), \$16 (non-

members) – by calling the college's circulation department at (800) 523-1546. And IDPH is developing a chart listing the indications for various vaccines.

These guidelines, together with a thorough medical record review, should indicate if a patient has been adequately immunized or requires additional immunization. "If there is no record of immunization, question the patient," Galati suggested. If immunization history is still unclear, he said the rule of thumb is "go ahead and vaccinate."

"Of course, the decision to vaccinate should be made on a case-by-case basis, depending on susceptibility to the disease and known risk factors," said Arvind K. Goyal, M.D., ISMS president and a Rolling Meadows family physician.

**HEALTH CARE PROVIDERS CAN** help prevent unnecessary vaccine duplication by providing patients with a written record of their immunization history. Each vaccination should be recorded in the patient's history, as well as the provider's records, noting when the next immunization is due. IDPH offers "personal vaccination cards" for physicians to complete and provide to their patients. These are available through local health departments or regional public health offices, or by calling IDPH at (217) 785-1455.

"Whether to vaccinate is a question of what is critical. Prevention often is not deemed critical, particularly in a difficult economy," said Bob Howard, a CDC spokesperson. "There's no question that immunizations are one of the most cost-effective methods of treatment we have." If providers begin to make vaccinations a routine part of their practice, he said, "we're bound to see long-term cost savings." ■

## Adults need immunization for the following diseases

### Influenza

The following groups should receive influenza vaccine yearly and pneumococcal vaccine at least once:

- People over 65
- People with chronic conditions such as heart and lung disease
- People with diabetes
- People with renal disease

### Diphtheria and tetanus

After primary immunization against tetanus and diphtheria, all adults should receive a booster dose every 10 years.

### Measles, mumps, rubella

All adults should be immune to measles, mumps, rubella, diphtheria and tetanus. Generally, a single dose of measles-mumps-rubella (MMR) trivalent vaccine is considered adequate immunization, but a second dose of measles vaccine (given as MMR) is recommended for:

- College students
- Medical personnel
- People traveling abroad to endemic areas
- All people at risk during outbreaks of measles

### Hepatitis B

Certain adults are at high risk for hepatitis B and should receive the vaccine, a series of three injections over six months:

- People with occupational risk, such as health care and public safety workers who are exposed to blood, blood products and body fluids that may be contaminated with blood;
- Sexually active heterosexuals
- Clients and staff of institutions for the developmentally disabled
- Hemodialysis patients
- Sexually active homosexual men
- Users of illicit injectable drugs
- People with clotting disorders who frequently receive certain blood products
- Household and sexual contacts of hepatitis B carriers
- Certain international travelers
- Certain other groups such as adoptees from countries of high hepatitis B endemicity

Note: Polio vaccination is not routinely recommended for people over 17. Source of data: Illinois Department of Public Health.



## TEEN HEALTH

LINDA K. HENSON



*Stores are very lenient and don't card kids. Anybody can buy cigarettes, and [the store owners] don't do anything.*

— Cory Huff, 16  
East Peoria High School

*We don't even have a movie theater or a shopping mall within a 30-minute drive, and so a lot of people drink because of boredom.*

— Paula Stephens, 16  
Casey-Westville High School



PHOTO COURTESY OF THE CASEY REPORTER

WM. DANIELS/THE PHOTO PARTNERS



*A lot of people think it is a cool thing to have as much sex as you can, with whoever you can. People think that the main problem with having sex is getting pregnant, but they forget that it is a lot easier to contract diseases ... by sleeping around.*

— Sarah Haque  
Oak Park and River Forest High School

# Sex, drugs & Teen health choices

*In October, Child Health Month on their greatest health concern potentially deadly growing*

**S**tate teen birth rate up third year in a row," "AIDS surging among teens," "Kids getting drunk at an earlier age," "Teens at high risk for mental illness," "Teens ignore health risks." The headlines don't look promising. As teen health issues consistently grab the media's attention, an unfortunate message is coming through: Being a teen in the 1990s isn't easy. Sexually transmitted diseases, unplanned pregnancies, and alcohol, tobacco and drug abuse are just some of the top health problems facing teenagers today.

"The adolescent is really an endangered species," said Luke L. Burchard, M.D., a family physician from Mattoon. "The ultimate dilemma is finding out what makes kids tick."

Dr. Burchard, who also serves as the vice president of Doctors Ought to Care — a national physician group educating teens on lifestyle-related health problems — believes teens are not taking their health seriously.

The first step, he maintained, is making teens responsible for their health and teaching them that "being healthy is the way to go."

Many teens and physicians agree that alcohol is the most widely used and abused drug today. A study from the Illinois Department of Alcoholism and Substance Abuse found that among Illinois high school seniors, more than 89 percent reported having used alcohol at some time in their life, with 57 percent having used it in the past month. The study also found that the incidence of alcohol abuse is evenly distributed throughout all Illinois counties.

"When teenagers look at alcohol, they don't look at it as a serious drug; they look at it as the 'safe' alternative to drugs," said Dr. Burchard.

Paula Stephens, a student at Casey-Westville High School in Clark County, cited alcohol abuse as the No. 1 teen health problem in the rural county.

"I live in the country," explained the 16-year-old senior. "We don't even have a movie theater or a shopping mall within a 30-minute drive, and so a lot of people drink because of boredom."

Eighteen-year-old Ruffin Howard, a student at Wheaton-Warrenville South High School near Chicago, agreed that the lack of social activities is a major reason teens turn to alcohol.

"There is nothing out there for kids to do legally. [Teens] can't go out to the bars or dance clubs ... and if [they] go to a party, there's bound to be alcohol," Howard said. "Kids nowadays think drinking is the only way to have fun and have a good time."

In Casey, older siblings usually buy alcohol for minors, said Stephens. Experts believe this easy access contributes to the widespread alcohol abuse problem.

**THE SAME PROBLEM EXISTS** with the sale of tobacco products to minors, according to Cory Huff, a student at East Peoria High School. Access to



## TEEN HEALTH

# rock 'n' roll matter of life or death

Illinois Medicine surveyed teens  
and found few answers to these

ISS. BY RACHEL BROWN

cigarettes and smokeless tobacco, a growing problem among Peoria-area teens, is easy because of the lax attitude of area businesses, he said.

"Stores are very lenient and don't card kids. Anybody can buy cigarettes, and [the store owners] don't do anything," he said.

In Illinois, people under the age of 18 cannot legally buy alcohol or tobacco products, although several studies have shown that very few cigarette merchants abide by the law.

Doctors and Lawyers for a Drug-Free Youth, a research group founded by Dr. Burchard that focuses on underage alcohol and tobacco issues, last year conducted "sting" operations in 31 Illinois communities and found 84 percent of merchants sold cigarettes to underage girls and boys.

"[This study proves] that youth access to this addictive and lethal substance is free and easy in our society ... and that nobody on the state level cares one hoot about enforcing these laws," said Dr. Burchard.

According to Dr. Burchard, the federal government has taken a giant step toward combating the problem by passing legislation requiring states to follow the law or lose federal funds.

Dr. Burchard strongly endorses legislation restricting the availability of cigarette vending machines. Chicago has been successful in curbing tobacco use among minors by passing an ordinance last year banning such vending machines in all public areas except taverns.

**ANOTHER MAJOR HEALTH ISSUE** for teens is increased sexual activity, said Sarah Haque, a senior at Oak Park and River Forest High School in suburban Chicago. Part of the increase, Haque believes, comes from teenagers' desire to be sexually experienced.

"A lot of people think it is a cool thing to have as much sex as you can, with whoever you can. People think that the main problem with having sex is getting pregnant, but they forget that it is a lot easier to contract diseases ... by sleeping around," she said.

Felicia Townsend, a senior at Hyde Park Career Academy in Chicago, cited sexually transmitted diseases as one of the most serious and growing problems in her area.

"Students are not aware of how to protect themselves, are ignorant to the facts or just don't care. They have the attitude that it just won't happen to them," said Townsend.

Dr. Burchard said students are more likely to engage in high-risk behaviors when their defenses are down. "A lot of the problems with STDs and pregnancy seem to occur under the influence of [alcohol or drugs]," he said.

Virginia Anderson, executive director of the Links North Shore Youth Health Services in Northfield, also pointed out that troubled teens often are unable to share their problems with their families, leading to other problems like substance abuse, depression or suicide.

(Continued on page 18)

## Patient confidentiality vs. parental consent

BY JANICE ROSENBERG

Physicians whose patients include minors should be aware of their responsibilities to parents and legal guardians. According to Illinois law, all patients under the age of 18 are minors. For the most part, physicians who provide medical and surgical services to minors must have parental consent to do so. However, nothing in the statutes indicates what type of consent – a signed, dated note for a specific treatment; a general note of approval; or a telephone call – must be presented if a child goes alone to see a physician. To be safe, physicians should make sure that the consent, in whatever form, is genuine.

There are some exceptions to this general parental consent rule:

- Minors who are parents, married or pregnant are considered to be of legal age and may consent to medical or surgical procedures for themselves.
- Minors may be given emergency treatment or first aid without parental consent.
- Minors who are victims of sexual assault or abuse may be treated without parental consent when obtaining consent is not reasonably feasible without affecting the minors' health.

For certain services and situations, physicians should follow specific rules when treating minors.

**Birth control services** – Physicians need parental consent *except* in the following situations:

- Minors who are married, parents or pregnant may receive birth control services without parental consent.
- Minors who are referred for birth control services by a physician, a clergyman, or a Planned Parenthood or other family planning agency may be treated without parental consent.
- Treatment may be provided without parental consent when failure to treat minors would create a serious health hazard.

**Venereal disease and chemical abuse** – Consenting minors between ages 12 and 18 may receive these services without parental consent. However, the physician should try to involve the family in the treatment if the minor agrees and if the physician feels that family involvement would not be detrimental to the child.

There are exceptions to this rule. Parental consent must be obtained when

- A physician provides more than two treatments related to alcohol use; or
- A mental health facility provides a minor between the ages of 12 and 17 with more than five 45-minute treatment sessions.

**Child abuse and neglect** – Under Illinois law, physicians must report cases of suspected abuse and neglect to the proper authorities. These reports are not considered privileged, which means any communications and records regarding these reports can be obtained by law enforcement and child welfare agencies that need them for their investigations.

**Dissolved marriages** – According to Illinois law, after a divorce, both custodial and noncustodial parents have the right to access to their children's health care information and records. Although both may also make health care decisions for their children, the terms of a divorce may affect these rights. Physicians who are aware of a divorce may want to ask the custodial parent whether the decree includes any specifics regarding health care. Unless physicians are advised of contrary terms in the decree, they are authorized to discuss health matters with either parent.

**AIDS testing** – A new Illinois law states that health care providers are exempt from criminal penalties for either notifying or failing to notify the parents or legal guardian of a child who tests positive for HIV. The law requires physicians to encourage minors to speak to their parents about the test results prior to the time the parent might be contacted by the physician or other health care worker.

ISMS General Counsel Saul Morse also contributed to this article.



## Sex, drugs & rock 'n' roll

(Continued from page 17)

"The tragedy is that a lot of times teens are isolated because they don't want to disappoint their parents or are afraid of their parents, and they must deal with these hard-core issues all by themselves," said Anderson.

To make it easier for Illinois teens to reach out for help, the Illinois State Medical Society Auxiliary has produced a Teen Support Resource Card. The wallet-sized cards, which have been dis-

tributed to all organized county medical society auxiliaries, contain telephone numbers of various information and referral groups for teens, said Carol Gapsis, ISMS Auxiliary president.

"There are so many ways these can be distributed," said Gapsis. "They are ideal for doctors' offices, police departments and high schools."

Physicians also can be key players in educating teens about the health care

dangers out there. Programs such as ISMS' "AIDS and Adolescents" give volunteer physician-speakers the chance to provide students with important information on AIDS and other health care issues.

"[Physicians] have to take the information to where the students are; they have to be willing to roll up their sleeves, go to their local schools and teach teens about what's going on," said Dr. Burchard. "We must make kids realize that they are responsible for their health, but we must also give them the tools to resist [these temptations]." ■

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## OBITUARIES

\* indicates ISMS member

\*\* indicates member of ISMS Fifty Year Club

### \*Bader

Karl F. Bader Jr., M.D., a plastic surgeon from Rockford, died May 16, 1992, at the age of 56. Dr. Bader was a 1960 graduate of the University of Illinois College of Medicine, Chicago.

### \*Cece

Joseph D. Cece, M.D., an allergist from Willowbrook, died July 14, 1992, at the age of 60. Dr. Cece was a 1955 graduate of the University of Illinois College of Medicine, Chicago.

### \*Elliot

Victoria L. Elliot, M.D., a general practitioner from Glenview, died May 12, 1992, at the age of 75. Dr. Elliot was a 1943 graduate of Northwestern University Medical School, Chicago.

### \*Jakopin

Robert L. Jakopin, M.D., an anesthesiologist from Peoria, died May 3, 1992, at the age of 57. Dr. Jakopin was a 1959 graduate of Loyola University Stritch School of Medicine, Maywood.

### \*\*Oselka

Adam Oselka, M.D., a general practitioner from Chicago, died May 16, 1992, at the age of 81. Dr. Oselka was a 1937 graduate of Facolta di Medicina e Chirurgia dell'Universita di Bologna, Bologna, Italy.

### \*Reiser

Howard G. Reiser, M.D., a surgeon from Joliet, died May 22, 1992, at the age of 70. Dr. Reiser was a 1945 graduate of the Pritzker School of Medicine of the University of Chicago.

### \*Richardson

Robert J. Richardson, M.D., a plastic surgeon from Peoria, died April 29, 1992, at the age of 67. Dr. Richardson was a 1951 graduate of the Medical College of Wisconsin, Milwaukee.

### \*\*Shalgos

Edward J. Shalgos, M.D., a forensic pathologist from Frankfort, died July 19, 1992, at the age of 81. Dr. Shalgos was a 1938 graduate of Loyola University Stritch School of Medicine, Maywood.

### \*Thompson

James R. Thompson, M.D., a pathologist from Oak Park and father of former Illinois Gov. James Thompson, died Sept. 25, 1992, at the age of 81. Dr. Thompson was a 1944 graduate of the University of Illinois College of Medicine, Chicago.





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## CDC lowers acceptable lead level

(Continued from page 1)

levels as low as 10 µg/dL can result in developmental delays and reduced stature.

The action levels recommended by Dr. Sullivan could range from individual treatment and case management to community prevention activities that could help protect children nationwide.

"Lead poisoning is one of the most common pediatric health problems in the United States today and is entirely preventable," said HHS Assistant Secretary for Health James O. Mason, M.D. "Three to 4 million children under age 6 in the United States have blood levels greater than 15 µg/dL of whole blood. This is far greater than the number of children affected by other common childhood illnesses."

LAST FEBRUARY, DR. SULLIVAN unveiled a 20-year plan, the "HHS Strategic Plan to Eliminate Childhood Lead Poisoning," which described public- and private-sector efforts to attack the problem. The U.S. Department of Housing and Urban Development in 1990 and the Environmental Protection Agency in 1991 also developed plans to eliminate lead hazards.

"We owe it to our children to work together toward further improvement," said Dr. Sullivan. "We need to identify and treat youngsters with high blood lead levels, and we need to keep working

in our communities to control childhood lead exposure."

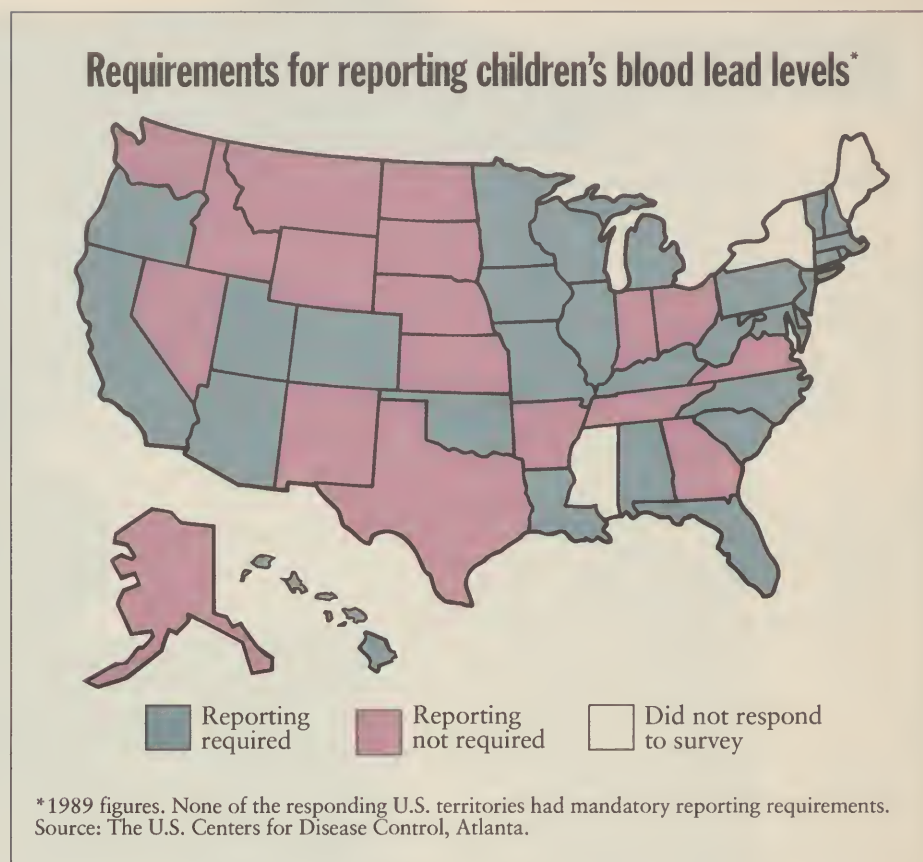
The new CDC statement provides action guidelines for preventing and treating childhood lead poisoning for parents, pediatricians, public health officials and government agencies. The guidelines recommend that children with blood lead levels exceeding 20 µg/dL be medically evaluated and that the lead exposure source be located and removed.

Children with blood levels of 15 µg/dL to 19 µg/dL should receive individual case management, including nutritional and educational intervention and more frequent screening, according to the CDC statement. If high levels continue, a home inspection and environmental investigation are recommended.

Communities in which many children are found to have levels of 10 µg/dL or higher should begin community-wide prevention activities, the agency recommends.

Some groups have lobbied Congress to mandate universal screening and national surveillance – two activities that should be phased in, said Dr. Sullivan, except in areas where large numbers of children have been screened and found unexposed.

In the past, testing for lead was done through free erythrocyte protoporphyrin (EP) screening; now it must be done with



a laboratory blood test, since EP screening is not reliable below levels of 25 µg/dL.

Dr. Sullivan noted that until a cheaper, easier method of measuring blood lead levels is available, universal screening should be used, but he acknowledged that it is not a prevention and detection

tool that can be implemented immediately. However, a national surveillance plan is one component of HHS's 20-year plan.

A survey conducted in 1991 by the CDC and the Council of State and Territorial Epidemiologists shows that in 1989, 28 states and the District of Columbia required reporting of blood lead levels in children. All states reported various regulation differences in who reports, how they report, which laboratories must report, and which levels required reporting. Twenty-four states specified ages for which reporting was required – 23 of them starting at birth.

IN ILLINOIS, ONE BILL DEALING with lead testing and another with lead abatement – both supported by the Illinois State Medical Society – have been signed into legislation.

Gov. Jim Edgar signed H.B. 2295 into law Aug. 30, 1991. The law mandates that physicians screen all children between the ages of 6 months and 6 years for possible lead poisoning, according to American Academy of Pediatrics guidelines. It requires that by Jan. 1, 1993, all children entered in a day care center, nursery school, preschool or kindergarten provide proof of screening.

H.B. 3638, signed Sept. 17, parallels 1992 ISMS House of Delegates policy. The law addresses the means by which to control the most common sources of environmental occurrences of lead and represents the combined efforts of the health care community, citizens' groups and the real estate industry.

"Now it is up to all of us to work together – to treat children who are affected, and to reduce and prevent lead poisoning in the future," said Dr. Sullivan. "This statement will help all of us focus on that goal – physicians, parents and community leaders, as well as public officials at the state and federal level."

Exposure to lead, particularly in children, can cause serious health problems. When poisoning is undetected, it can lead to learning disabilities, IQ deficits and neurobehavioral problems, said the CDC. Lead can be found in old paint and in some ceramic dishes – sources that can be avoided or suspected and

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removed. But the "silent health threat" of lead poisoning can affect unsuspecting families: Lead is often found in the plumbing of older homes and buildings, leaching into the water inhabitants drink, or it is absorbed into the surrounding soil from lead-based paint or automobile gasoline fumes.

The CDC last month outlined a public awareness plan on childhood lead poisoning, designed to work with HHS' 20-year plan. The public awareness campaign's three immediate objectives include answering the public's questions on the new blood lead level, educating the public about the magnitude of the lead poisoning problem in children, and defining a hands-on prevention role for the public.

The CDC's key health messages will help inform the public of the following major lead poisoning facts:

- Lead poisoning affects virtually every

system in the body.

- Most poisoned children do not have any distinctive or evident symptoms until the toxicity increases in severity.
- Lead poisoning is totally preventable if children are removed from the exposure sources and given appropriate medical care.
- Exposure to lead can cause neurobehavioral problems, learning disabilities and deficits in IQ.
- Damage from regular exposure to lead is usually irreversible.
- Blood lead levels as low as 10-15  $\mu\text{g}/\text{dL}$  of whole blood usually result in subtle developmental effects such as

behavioral disturbances and reduced stature.

- Studies show that maternal and cord blood lead levels of 10-15  $\mu\text{g}/\text{dL}$  are associated with reduced gestational age and reduced birth weight.
- Screening and treatment are essential to eliminate the disease. Copies of the CDC's "Preventing Lead Poisoning in Young Children" are available by writing to the National Center for Environmental Health and Injury Control, CDC, 1600 Clifton Rd., Atlanta, Ga. 30333. ■



Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654 from 8:30 a.m. to 4:45 p.m. Monday through Friday.

In addition, ISMS President Arvind K. Goyal, M.D., is available for calls the first Wednesday of every month at extension 1333. ■

## IEPA advises getting the lead out of houses

As health officials and the media release urgent reports on lead poisoning, many people wonder, "Is my water safe?"

The answer, said an Illinois Environmental Protection Agency spokesman, is, "Yes, definitely, state water supplies are lead-free."

What may not be lead-free, though, he added, are the pipes it travels through to get into your drinking glass.

"There is no lead in the public water supply," said Leonard Lindstrom, supervisor of the Division of Public Water Supplies in Elgin. "But people may be getting lead from their plumbing, if it contains lead."

The IEPA recommends that consumers take a few precautions to minimize possible exposure to lead, or if they suspect a home-based hazard, to eliminate lead from their homes.

"We tell people to try to get the lead out of their houses," Lindstrom said. "Lead as a preservative in paint has been banned since the 1970s. Use of lead plumbing in the state has been illegal since 1986. But if you have an older home, you could have a problem."

Consumers should turn on their water first thing in the morning and let the tap run for a minute or so to clear out possible lead deposits that collect overnight, he said. They should also use cold tap water and avoid using hot or boiled tap water, particularly for cooking or mixing infant formula, since heat tends to dissolve lead in pipes and concentrates the lead.

Those who suspect a lead problem should have their water tested by a certified laboratory, Lindstrom added.

"Although you want to avoid consuming the first bit of tap water run in the morning, that is the best time to take test samples," he instructed. "That is the sample that will have the greatest concentration of lead." ■

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## June 1992

Mahendi M. Jamal, Chicago – physician and surgeon license indefinitely suspended after being convicted of criminal sexual abuse of patients.

Young Keon Jeon, Grayslake – physician and surgeon license indefinitely suspended for two alleged cases of gross negligence.

Kastytis A. Jucas, Chicago – physician and surgeon license placed on probation for three years and fined \$5,000 after submitting incorrect claims to insurance companies for reimbursement.

## July 1992

Brian K. Bevacqua, Urbana – physician and surgeon license suspended indefinitely after failing to answer Department complaints.

Frederick Cohn, Albuquerque, NM – physician and surgeon license issued and placed on probation indefinitely after discipline by the state of New Mexico for gross negligence in performing an abortion.

Karen Lee DeLuca, Oak Brook – physician and surgeon license issued on probation for five years after discipline by State of Minnesota.

Gilbert A. Masterson, Northbrook – physician and surgeon license reprimanded and fined \$5,000 for prescribing controlled substances without a current license.

Yvon Nazon, Chicago – physician and surgeon license placed on probation to run concurrently with probation in Indiana after being disciplined for making false claims to United States Department of Health and Human Services.

Richard Lee Phillis, Moline – physician and surgeon license reprimanded after alleged gross negligence in diagnosis of a patient.

Urduja Pulido, Murphysboro – physician and surgeon license suspended indefinitely after alleged negligence, dishonorable and unethical conduct, filing false records with Public Aid, practicing on an expired controlled

substance license, and incompetence. Also, convicted of a felony in United States District Court.

## August 1992

Wesley E. Choy, Kankakee – physician and surgeon license reprimanded and fined \$5,000 after performing arthroscopy on wrong knee of patient.

Charles Petersen, Tucson, AZ – physician and surgeon license reprimanded after Arizona and federal controlled substance licenses were surrendered for improper recordkeeping and Ohio license was suspended for 90 days after failing to notify state of action taken by Arizona.

Tomas Rogers, New York, NY – physician and surgeon license was reprimanded after state of Florida license was disciplined for failing to meet continuing education requirements.

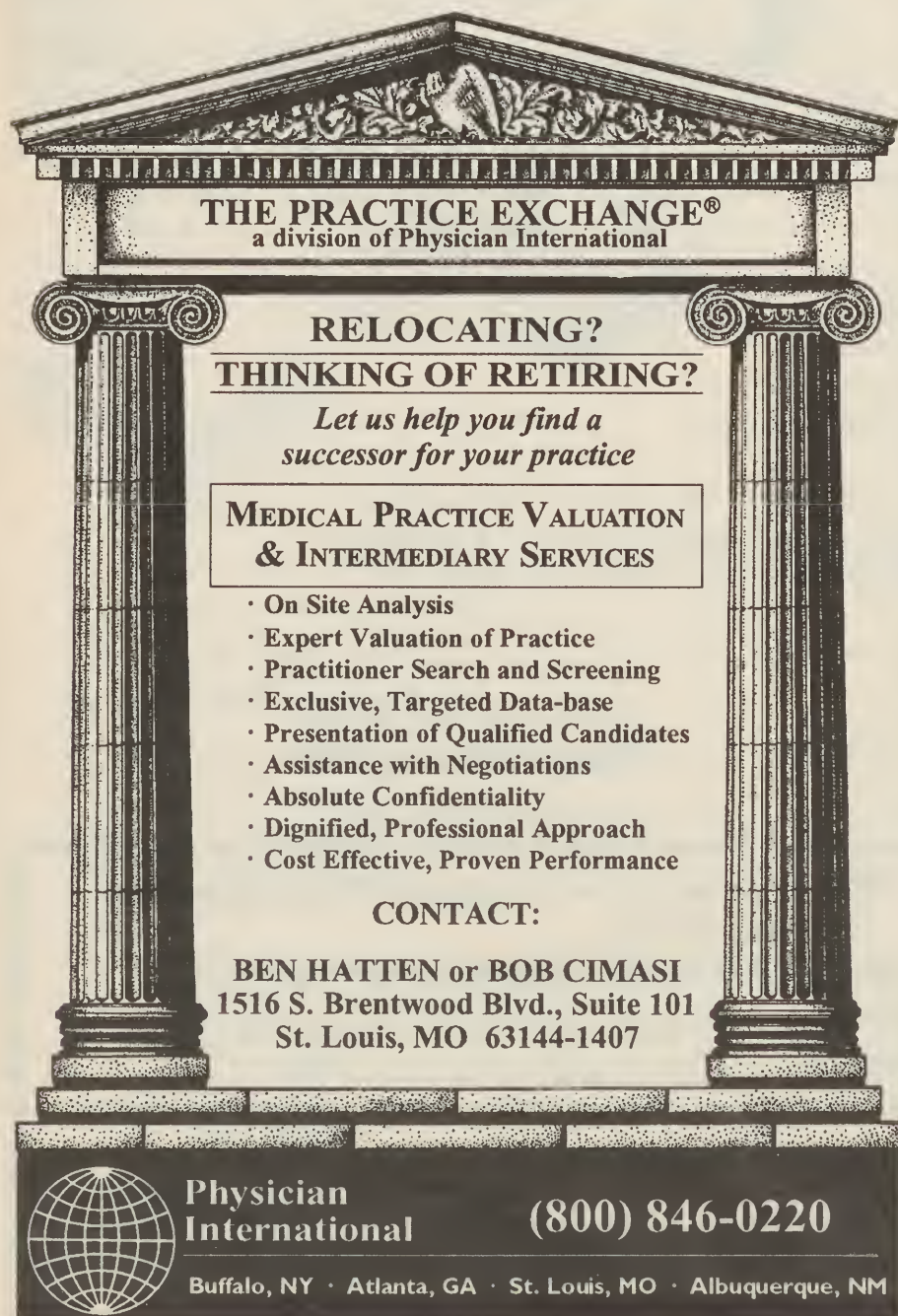
Than Tun, Aiea, HI – physician and surgeon license placed on probation for minimum of two years after Hawaii license was restricted from engaging in pediatric anesthesiology for minimum

of two years for incompetency to perform anesthesiology on pediatric patients.

Charles Westfall, Elmhurst – physician and surgeon license reprimanded after allegedly failing to diagnose and treat fetal distress in timely manner.

Sirisak Suntharasantic, Godfrey – physician and surgeon license placed on probation for one year and required to complete 100 hours of community service after ordering inappropriate medication and falsifying records.

*This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.*



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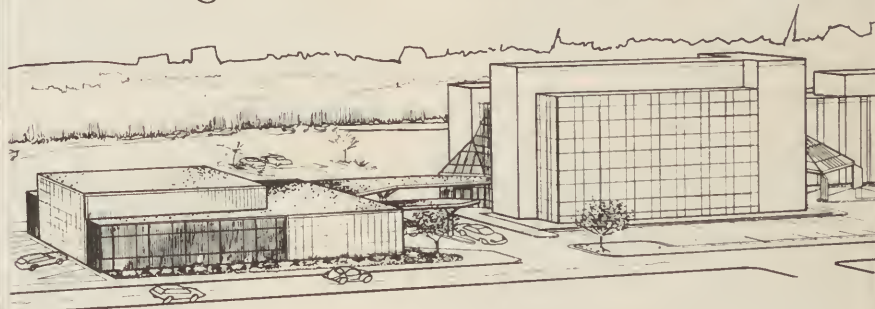
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## October Employee of the Month works behind the scenes

[ CHICAGO ] Becky Prochnow, Illinois State Medical Society field services secretary, was named Employee of the Month for October.

"Becky is accustomed to working anonymously, not taking credit for successfully arranging the president's tour and working with ISMS officers and trustees," said Suzanne Nelson, vice president of Governmental Affairs, at an Oct. 5 award presentation.

Prochnow's duties include "breaking in" new field representatives and coordinating their schedules as they travel throughout the state to work with physicians and county medical societies.

"Becky is a real detail person with a very, very long memory," Nelson said.

"She is one of the most loyal and skilled ISMS employees."

"It feels good to be recognized," Prochnow said accepting the award. "Everyone in Governmental Affairs/field services is great to work with. In fact, I work so closely with the field reps that I once called one by my husband's name."

**AT THE SAME CEREMONY**, underwriter Robin Moss was named Employee of the Month for September. Al Allphin, vice president of Underwriting, praised her "unflappability" and ability to effectively deal with crisis situations.

Although she was unable to attend the ceremony, Moss sent her thanks to those

who nominated her and said, "It's nice to be recognized by the people you work with. That's what makes this company work."

Both Prochnow and Moss received a plaque and a \$200 check. Their names will be inscribed on a plaque in the ISMS reception area listing each Employee of the Month.

All permanent, full-time ISMS/ISMS employees – except those at senior management level – are eligible for the award. Physicians who wish to nominate a staff member may call the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



October Employee of the Month  
Becky Prochnow.

## What works in indigent care

(Continued from page 1)

cians hope to encourage more of such efforts by providing a forum to learn from each other."

An estimated 1 million to 1.5 million Illinois residents don't have health insurance. Increasingly they are limited in their access to care, as medical costs continue to soar and public health programs become overburdened. Unable to pay for the most basic medical care, many delay medical treatment until their condition becomes severe. Others simply rely on their local hospital emergency room to provide routine medical care, contributing to the overcrowding in hospital emergency rooms.

Guest speaker Kevin C. Kelleher, M.D., a family physician from Roanoke, Va., who was instrumental in establishing the Bradley Free Clinic, will speak on the "practical approaches to the problems of the uninsured" and offer a "strong dose of the political realities" of the access problem. The Bradley Free Clinic in Roanoke is one of the nation's first free clinics and has served as the model for several others across the country.

In addition to Dr. Kelleher, representatives from indigent care programs across the state will be present at the November conference to share effective strategies for providing care to the poor. The strategies used by Illinois communities to reach indigent patients are as diverse as the patients themselves.

To address the medical needs of its community's poor, the Rock Island County Medical Society has established two physician referral networks, one for Ob/Gyn cases and one for primary care. The medical society set up the referral system after public health clinics failed due to lack of funding. Physicians in the referral network have agreed to see an established number of low-income patients a month.

Several other communities have set up free clinics staffed by physician and nurse volunteers to serve low-income patients who lack health insurance but don't qualify for Medicaid. The Will-Grundy County Medical Society opened the first free clinic in the state – the Will-

Grundy Free Clinic – in Joliet in March 1988. It was followed by the DuPage Community Free Clinic in Wheaton in May 1989, the Heartland Community Clinic in Peoria in December 1991, and most recently HealthReach in Waukegan. Other clinics are located in the Chicago area.

In some underserved rural areas, communities have launched aggressive efforts to recruit new physicians to serve the needy. Because locating to a rural area is often a matter of economic feasibility for a physician, the "community can be helpful in providing office space and access to low-cost loans, especially for young physicians. Many communities – even poor ones – can raise more money than they think is possible and build a health care system for their residents," said Eugene P. Johnson, M.D., co-chair, ISMS Committee on Health Care Access and a speaker at the conference.

This community support is key to any indigent care program, said Sister Lucille Adelman, R.N., executive director of the Will-Grundy Free Clinic. Physicians, community members and organizations have donated almost all the office and medical supplies and equipment needed. Pharmaceutical firms and physicians have contributed medications for on-site use; local pharmacies have agreed to fill other prescriptions at cost, which the clinic funds with donations. In addition local hospitals have agreed to provide rooms and ancillary services to clinic patients at no cost.

"By reaching out to the poor we hope to give them access to basic medical care and routine preventive care. Our rising health care costs can in large part be attributable to illnesses that could have been prevented or successfully treated if a diagnosis had been made earlier," said Robert M. Reardon, M.D., ISMS immediate past president. "We also hope that through these efforts the public comes to realize that physicians are part of the solution and not part of the problem in the health care reform debate."

For more information about the indigent care seminar, call (800) 782-ISMS. ■

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## MEMBERS IN THE NEWS

Peter J. Stecy, M.D., of Chicago, recently became the first physician in Lithuania to perform a mitral valvuloplasty, a nonsurgical procedure used to open a patient's constricted heart valve.

A cardiologist from Illinois Masonic Medical Center, Dr. Stecy performed the procedure at the University of Vilnius Santariskes Hospital in Lithuania during a trip to help train cardiologists in this and other interventional procedures.

The senior ranking dean among deans of the 126 U.S. medical schools is stepping down. Richard H. Moy, M.D., of Springfield, founding dean of the Southern Illinois University School of Medicine, has announced his intention to retire in September 1993. When Dr. Moy accepted the position in 1969 at age 39, he was the youngest dean of any U.S. medical school. Provost was added to his SIU title in 1974.

The SIU School of Medicine was one of more than a dozen community-based medical schools started in the 1960s to meet a projected physician shortage.

Dr. Moy's activities also include serving on the Illinois Health Service Corps Task Force for the Illinois Department of Public Health and the Governor's Task Force on the Future of Mental Health. He has been honored by the Society of Teachers of Family Medicine, the Illinois State Academy of Science, the Lincoln Academy of Illinois, and his alma mater, the University of Chicago. After he steps down, Dr. Moy will become dean emeritus, main-

taining an office at the medical school and continuing to represent it nationally.

Hassan M. Najafi, M.D., of Chicago, was recently named Mary and John Bent Endowed Chair of Cardiovascular-Thoracic Surgery. The Bent chair honors the memory of two long-time supporters of cardiovascular education and research.

Dr. Najafi, chairman of the department of cardiovascular-thoracic surgery at Rush-Presbyterian-St. Luke's Medical Center, performed the first successful adult heart transplant in Chicago in 1968. In addition to serving as director of the American Board of Thoracic Surgery and past president of the Society of Thoracic Surgeons, he is the assistant editor of the *Annals of Thoracic Surgery*.

The Board of Health and staff of the Fulton County Health Department recently honored William L. Carper, M.D., of Canton, for his contributions to public health. The board recognized Dr. Carper for his support and guidance over the years to maintain optimal public health standards for Fulton County.

A former member of the board, Dr. Carper provided advanced professional training for department staff and served as liaison between the health department and the medical community.

Dr. Carper is on staff at Graham Hospital Association in Canton, and in recent years worked as a medical missionary in Haiti and Honduras.

Raymond E. Bertino, M.D., of Peoria, clinical assistant professor of radiology, was recently awarded the Raymond B. Allen "Golden Apple" award from the sophomore students at the UIC College of Medicine at Peoria.

The purpose of the award is to let students "publicly recognize faculty members who have distinguished themselves by providing good teaching, and representing, in themselves, the highest of professional ideals." It was named after Raymond B. Allen, dean of the University of Illinois College of Medicine at Chicago from 1943-46.

Charles E. Seten III, M.D., of Harrisburg, was named the ninth chairman of the Southeastern Illinois College Foundation. A board director since 1983, Dr. Seten served as vice chairman last year.

The foundation is a not-for-profit corporation established to assist in fund raising and administering local scholarships and grants at the college.

J. Lewis Bailen, M.D., of Bloomington, is one of two recipients of the 1992 Illinois Health Promotion Award. The award was presented during the annual meeting of the Illinois Public Health Association.

Dr. Bailen, a retired pediatrician, operates a free medical clinic for children at the Western Avenue Community Center in Bloomington. The award automatically nominates Dr. Bailen for a Community Leader Award from the U.S. Secretary of Health and Human Services.

Bruce L. Gewertz, M.D., of Chicago, has been appointed the Dallas B. Phemister professor and chairman of the department of surgery at the University of Chicago Medical Center.

A specialist in vascular surgery, Dr. Gewertz served as director of surgical education at the university from 1981 to 1989 and is currently faculty dean for medical education and a councilor for the university Senate. He is editor of the *Journal of Surgical Research*, editor for basic science and book reviews at the *Annals of Vascular Surgery* and a member of the editorial board of *International Vascular Surgery*.

Dr. Gewertz is also a consultant to the American Board of Surgery, chairman of the program committee for the Central Surgical Association and past president of the Association for Surgical Education.

Richard B. Lazar, M.D., of Chicago, has joined the Schwab Rehabilitation Hospital and Care Network as executive vice president of medical affairs and medical director.

A fellow of the American Academy of Neurology, Dr. Lazar came to Schwab from the Rehabilitation Institute of Chicago. For the past two years, he has been an assistant professor in the department of neurology and rehabilitation medicine at Northwestern University Medical School. ■

## The Hospital Medical Staff Section Twentieth Assembly Meeting December 3 - 7, 1992 Opryland Hotel Nashville, Tennessee

Medical Staffs from the country are encouraged to elect a medical staff representative to participate in the AMA-HMSS Assembly Meeting December 3 - 7, 1992, Opryland Hotel, Nashville, Tennessee.

The HMSS Assembly provides medical staffs with a unique opportunity to discuss and participate in the policymaking process of the AMA. In addition to the Assembly Meeting, an educational program on:

- Part 1: A Futurist's Picture of Health Care 2000
- Part 2: Physician/Hospital Organizational Models for the future

If you are unable to participate in the Nashville Meeting, we encourage you to call us with the name of your HMSS Representative.

For future information about the AMA-HMSS, please call 312 464-4754 or 464-4761.

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## Exchange rates based on loss experience over time

(Continued from page 9)

during the first year will be reported by patients that same year. When the policy is renewed the second year, the exposure period expands and the premium increases accordingly. This "step" process is the natural progression of claims-made coverage and allows for the collection of the appropriate amount of premium over a longer period of time.

Premiums will continue to increase annually until a "mature" level is reached, Dr. Boren added. For the Exchange, this occurs during the seventh year of maturity. After the seventh year, any adjustments to the premium will result from the company's overall loss experience, which is calculated annually.

New Exchange rates go into effect with each new policy year, starting July 1. "To have the new rates set by July 1, the Exchange begins looking at specialties and territories as early as December," Dr. Boren said.

In 1992, the Exchange found it was able to provide professional liability insurance to its policyholders without raising the base premium. Although it cannot guarantee that rates will remain unchanged each year, careful planning coupled with an aggressive defense strategy help the Exchange bring the best values possible to its customers, Dr. Jensen

said.

"Premiums and investment earnings are the Exchange's two main sources of income," Dr. Boren said. "And a consistently favorable portfolio return is also a key element in the premium rate and development process." ■

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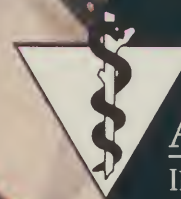
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- Effective 24-hour control<sup>2</sup>
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- No adverse effects on total cholesterol, plasma glucose levels, renal function,<sup>‡</sup> or serum electrolytes<sup>3-6</sup>

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\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

**References:** 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil In Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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# Illinois Medicine

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PAGE 4

## Illinois receives \$2.2 million grant for children's immunization

[ CHICAGO ] Gov. Jim Edgar announced Oct. 5 that Illinois has received a \$2.2 million federal grant to help the state reach its goal of immunizing at least nine out of every 10 children before their second birthday by the year 2000.

The Illinois Department of Public Health was awarded \$1.6 million and the Chicago Department of Health received \$645,275 from the \$45 million disbursed by the U.S. Department of Health and Human Services as part of a strategy to increase access to immunizations.

"Each year, thousands of children suffer from childhood diseases that are totally preventable with the correct immunizations," Edgar said. "This tragic toll of unnecessary childhood diseases must be reversed. Our challenge is to improve the delivery of lifesaving vaccines to children at the appropriate age."

In Illinois, outside of the city of Chicago, 57 percent of preschool children are properly immunized against childhood diseases, compared with only 29 percent in Chicago and about 50 percent nationwide.

(Continued on page 22)

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PHYSICIANS WHO work in correctional institutions may practice under lock and key, but they say the rewards often outweigh the restrictions. Art Brewer, M.D. (right), medical director at Stateville Correctional Center in Joliet, strives to debunk the myths surrounding prison care. See story, page 12.



TERRY VITACCO

## FDA official announces revisions to CME enforcement policy

**CME:** The third annual CME provider-industry conference strikes a note of cooperation and optimism, tempered by formidable challenges. By Kevin O'Brien

[ CHICAGO ] As a U.S. Food and Drug Administration official promised publication of final guidelines on enforcement of commercial-supported continuing medical education "in the very near future," participants in a recent national conference of CME representatives cautiously proclaimed a new era of dialogue and cooperation.

"The FDA recognizes the inherent sensitivity of govern-

ment in the information marketplace and especially in the free flow of scientific information among scientists," Michael R. Taylor, the FDA's deputy commissioner for policy, told more than 300 CME representatives of medicine, academia and the pharmaceutical industry who gathered Oct. 8-9 at Chicago's Stouffer Riviere Hotel for the Third National Conference on CME Provider-Industry Collaboration in CME.

The meeting was hosted by the American Medical Association's Division of Continuing Medical Education, in association with 15 organizations that either accredit or present CME programs. Conference planning was the responsibility of the 35-member Task Force on CME Provider-Industry Collaboration, formed three years ago to address increasing professional and congressional concern

about questionable promotional practices in industry-sponsored CME programs.

"I believe the process followed to this point is an excellent example of public-private collaboration," said Stephen J. Jay, M.D., chairman of the Accreditation Council for Continuing Medical Education. In March the ACCME adopted stringent standards governing accreditation of industry-sponsored CME programs nationwide.

The object of the participants' measured enthusiasm was ironically a revised version of an unreleased FDA paper establishing the government's ground rules for industry-sponsored CME. The fact that most attendees already had obtained a copy of a "nonexistent" May 4 document was the subject of some humor during the confer-

(Continued on page 21)

### ISMS PERSPECTIVE

## AFTER YOU VOTE, THEY WILL VOTE

Take a look at whom you voted for and who won. The winners will now be deciding many factors affecting the way you practice medicine. That is why it's so important physicians and their families understand that decisions made in the voting booth affect decisions made in Springfield and Washington.

Illinois State Medical Society members played a big part in this year's elections, particularly in helping David K. Deets, M.D., the only physician in the state legislature. Dr. Deets, a general surgeon in Dixon, was

appointed to the House to fill a vacancy in March of this year. He has served ably and has been a substantive help to other legislators in understanding medicine's views on important issues. A Loyola Medical School graduate, Dr. Deets received enthusiastic help in his campaign from medical families in his district and from physicians throughout the state.

Dr. Deets' opponent was Pennie L. von Bergen Wessels, a nonpracticing lawyer whose campaign materials slammed Deets for

(Continued on page 2)

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M. CANDEE STUDIOS



**HEALTHTECH SERVICES CORP.'S** Home Assisted Nursing Care device ("HANC," at right), was featured at the University of Illinois at Chicago's Neuropsychiatric Institute exhibit, "Neuroscience in the 21st Century." HANC is a computer-based, speech-activated device that communicates verbally with users, and can be programmed to take blood pressure, pulse, temperature and ECG; dispense packaged oral medications; and make telephone calls on demand if it detects problems. The Sept. 24-26 exhibit at UIC was designed to forecast the future of health care.

## Number of women using mammography increases

[ WASHINGTON, D.C. ] In the last 10 years, women have increased their use of mammograms. The Jacobs Institute of Women's Health, in Washington, D.C., conducted a 1992 phone survey of 980 women aged 40 and older that updates data from a similar survey in 1990.

The following were key findings:

- The number of women who have had a mammogram increased to 74 percent, from 64 percent in 1990.
- The major increases occurred among white women, women with at least a high school education and women with incomes of more than \$25,000 per year. There was no change among African-American women.
- Seventy-six percent of women who have had a mammogram said their physician recommended it; a similar percentage indicated a physician recommendation in 1990.
- The number of women who adhere to American Cancer Society screening guidelines has increased to 41 percent, from 31 percent.

The institute is an independent, non-profit organization founded by the American College of Obstetricians and Gynecologists to study and disseminate information about women's health. ■

## Appeals judges rebuke parties in Cook County Hospital abortion case

[ CHICAGO ] Observing that Cook County government "seems to be running like a mom-and-pop grocery," two Illinois Appellate Court justices severely rebuked the parties in the Cook County Hospital abortion case for not legislatively resolving the dispute.

During an Oct. 14 hearing in the mat-

ter, Justices Anthony Scariano and Gino I. Divito repeatedly interrupted lawyers for five Cook County commissioners and Cook County Board President Richard J. Phelan to express their displeasure. At issue was an appeal of Cook County Circuit Court Judge Thomas J. O'Brien's ruling that Phelan did not exceed his authority when he signed an executive order reinstating elective abortions at the public hospital. About 120 abortions have been performed since the procedure resumed Sept. 17, Pam Smith, Phelan's press secretary, said Oct. 22.

Saying the parties have "truly shirked their responsibility," Divito added, "There are 17 members of the County Board, any one of whom can take it upon themselves to settle the issue in an appropriate legislative forum. I urge the parties' lawyers to take that message back."

"The [County] Board can go across the street and enact a policy right now, and yet we're here arguing whether Phe-

lan has the power to make policy," said Scariano. He added that the situation is akin to "what Stockdale said - gridlock," alluding to a comment made by Ross Perot's running mate James Stockdale during the recent vice presidential debate.

The justices' comments echoed O'Brien's opinion, in which he wrote, "This is a perfect example of legislative timidity that seeks the comfort of submitting a controversial issue to the judiciary, inviting it to be a surrogate decision-maker on issues legislators were elected to decide."

While expressing their displeasure, the justices still extensively interrogated the lawyers on the factual and legal issues in the case. These include what constitutes county policy and who makes it - the board or the president; whether policy was clearly established in 1980, when the County Board "concurred" in then-President George Dunne's order halting elective abortions at the hospital; and whether Phelan's action substantively alters the form of county government practiced in Cook County.

"I won't shirk my responsibility in this case," said Scariano. "I and my colleagues will decide this case." It is not known when the court will rule, but a decision is expected by the end of the year. Both sides have previously indicated they might further appeal the case to the Illinois Supreme Court. ■

## IDPH gears up for flu season

[ SPRINGFIELD ] The Illinois Department of Public Health has begun its annual task of reminding Illinoisans that they may require flu shots. Medical Director John R. Lumpkin, M.D., stressed that the elderly and those with chronic illnesses should be vaccinated early to allow time to build up the necessary antibodies.

"Last year, Illinois and the nation were especially hard hit by influenza," Dr. Lumpkin said. "It is very difficult to predict from year to year how extreme the epidemic will be. For this reason, we urge people with chronic illnesses and those who want to decrease their chances of getting the flu to get their vaccine."

This year's program targets three

strains of flu: A/Texas, A/Beijing and B/Panama. Federal health authorities expect these strains to be the most virulent and dangerous this year.

To avoid a major epidemic, the Chicago Department of Health is offering flu shots administered by mobile health teams at various locations. Vaccinations are also being offered at various health centers, community centers and churches.

"We're telling people in the targeted populations to see their doctors and get a shot," said John Wilhelm, M.D., CDOH's acting chief medical officer. "Those who don't have a doctor or can't afford a shot can take advantage of the services we provide." ■

## Virginia firm wins 'Healthy Moms/Healthy Kids' case management contract

[ SPRINGFIELD ] A Virginia company has landed the contract to provide case management services in Chicago for the state's new "Healthy Moms/Healthy Kids" program.

Gov. Jim Edgar announced Oct. 26 that First Health Services Corp. of Glen Ellen, Va., has received an \$11.2 million contract to develop and operate a case management and computer tracking system to assure that mothers and children on Medicaid in Chicago receive regular medical care. First Health prevailed over three other companies, including two from Illinois, to win the contract. The contract with First Health will run from January through June 1993 and can be renewed for up to two years.

"Our 'Healthy Moms/Healthy Kids' initiative will serve 29,000 pregnant women and 357,000 children in Chicago," Gov. Edgar said in a press release. "The selection of First Health means we have taken a major step toward our goals of expanding access to medical care, improving overall health, lowering the infant mortality rate and holding the line on health care costs."

Edgar proposed the "Healthy Moms/Healthy Kids" program last April as part of his 1993 budget, saying it would improve the delivery of health care for low-income families by shifting emphasis to primary and preventive care and away from more expensive emergency care. The General Assembly approved \$19 million for the program, which will be administered by the Illinois Department of Public Aid. The program in Chicago is expected to be up and running in April.

The program will feature a community-based network of individual case managers who will regularly assist pregnant women and mothers with children

## PHYSICIAN FACTS

### Organ transplant waiting list, 1991-92

Organ	Illinois 10/1/91	Illinois 10/1/92	U.S. 10/1/92
Kidney*	819	975	21,592
Heart	99	109	2,583
Liver	79	162	2,149
Heart/lung	2	1	160
Lung	8	6	938
Pancreas	41	58	755
Total	1,048	1,311	28,177

\*Includes kidney-pancreas patients

Source: Regional Organ Bank of Illinois; United Network for Organ Sharing

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up to 5 years of age. "Case managers will help clients keep medical appointments, follow their long-term health care needs and assist with ongoing client education on nutrition and other important health topics," said IDPA Director Phil Bradley.

"The Illinois State Medical Society several months ago shared its suggestions for operation of the 'Healthy Moms/ Healthy Kids' program with the state, and we trust our input was incorporated into the requirements for the contract," said ISMS President Arvind K. Goyal, M.D. Dr. Goyal added that ISMS has been actively monitoring the development of this program and will consider support when further information is available.

Public service award presented to Chicago health commissioner

[ CHICAGO ] The first woman and first nonphysician to serve as commissioner of the Chicago Department of Health, Sister Sheila Lyne, RSM, received the 1992 Excellence in Public Service Award Oct. 28. The award is presented annually to a nonelected official who demonstrates creativity, innovation and a vision for better government.

Prior to Sister Sheila's appointment to the department, she served as chief operating officer of Mercy Hospital and helped salvage the bankrupt Mile Square Health Center, which reopened in 1991 as a project shared by the city and the University of Illinois.

The award was sponsored by Motorola Cellular Subscriber Group in conjunction with Crain's *City & State* newspaper, and NORBIC, the North Business and Industrial Council.

Elizabeth Hollander, chairman of the committee of business and industry leaders that chose Sister Sheila for the award, said, "The committee was unanimous in its choice. Sister Sheila Lyne is a firm leader with strong management skills. She has imbued a spirit of service to the health department staff."

NU researchers develop robot-assisted surgery

[ CHICAGO ] Researchers at Northwestern University's engineering and medical schools have developed a new method for knee replacement surgery that includes an industrial robot to position elements to reconstruct the knee.

The three-dimensional graphics system allows surgeons to preoperatively simulate the entire operation with images of a patient's bones, obtained through CT scanning, and develop the most effective plan for the operation.

During surgery, the robot receives information about the location and positioning of the patient's thigh bone and shin bone, correlates that data with stored data from the CT scan and demonstrates for the physician the precise angles to be drilled. The physician then carries out the actual procedure, replacing the end of the bones with titanium and synthetic materials.

"This project is opening the window

on a whole new approach that is going to be applicable to a number of fields," said David Stulberg, M.D., head of the research team and an associate professor at Northwestern University Medical School. The same technology that makes robotic surgery possible will also allow the development of "smart" operating rooms that are extensively automated and computer controlled, according to Stulberg.

Northwestern's project is one of two such research efforts under way. The second, at the University of California at Davis, is designed for hip replacement surgery.

Take your membership for a ride

If you are a member of the Illinois State Medical Society, your membership card can take you where you want to go – literally. As a benefit, ISMS members can receive a 10-percent discount on car rentals. The discount, valid on all Avis car rentals, lasts as long as you hold your membership. You can find the ISMS member Avis account number – A/A 604400 – on the back of your membership card. This number should be quoted to the Avis representative whenever you reserve a car. You may contact your local Avis dealer or call (800) 331-1212 from anywhere in the country. After you renew your 1993 membership, a card will be mailed to you.

Blue Cross Blue Shield REPORT FOR Illinois Physicians

BLUE SHIELD CROSSOVER IMPROVED FOR FASTER, EASIER PAYMENT OF YOUR BLUE SHIELD CLAIMS

NEW CROSSOVER GROUPS

As a service, Blue Cross and Blue Shield of Illinois implemented Blue Shield Crossover to eliminate claim filing to Blue Shield of Illinois for many of your patients with Medicare supplemental coverage. With Blue Shield Crossover, Blue Shield of Illinois automatically retrieves and processes your patient's Medicare Part B claim and remittance information for faster, easier payment of your claims. Blue Cross and Blue Shield of Illinois requests that you do not submit paper claims for services provided to members of the subscriber groups listed below—the Medicare Part B Electronic Media Claim (EMC) will automatically crossover to Blue Shield of Illinois for payment. New Crossover groups are highlighted below. To obtain updates to this listing, please contact Provider Assistance at (312) 938-7340.

13600	51161	53604	FEP
15600	51165	62305-10	FMR210
16600	51171	62312	H49766
20000-88, 90-99	51181	62314	H61013
20089	51191	62316	H64047
20700	53000	62326-28	H64048
22141	53006	62336-38	NO2807
22146	53050-51	63001-14, 16-18	NO6150
31685	53055	79156	P2300-04
32901-02	53057	80037	P2311
32904-06	53059	122141	P2313
32910-13	53063	120000-99	P2315
32920	53066-67	121000-99	P2317
32922-28	53070-71	220000-99	P2321-28
32930	53073-75	230000-99	P2330-38
49285	53078-79	240000-99	P2921-28
50354	53082-83	250000-99	P02807
51111-12	53086	260000-99	PO6150
51120-21	53087	270000-99	P19600
51130-31	53090-91	280000-99	P22141
51150-51	53094-95	992715	P21000-99

EXPLANATION OF BENEFITS AND PROVIDER CLAIM SUMMARY

The following messages indicating that the Medicare Part B claim has crossed over automatically to Blue Shield appear on the beneficiary's Medicare B Explanation of Benefits (EOB) and the Medicare B Provider Claim Summary.

EXPLANATION OF BENEFITS

This information is being sent to your supplemental carrier for further consideration.

PROVIDER CLAIM SUMMARY

This claim has been forwarded to the patient's complementary insurer.

If this message is not shown for your patients with Blue Shield supplemental coverage, please file a paper HCFA-1500 to Blue Shield of Illinois and attach a copy of the EOB or the Provider Claim Summary.

PLACE OF SERVICE CODES UPDATE

Blue Shield of Illinois is now accepting the new two-digit Place of Service (POS) codes required by Medicare Part B. If you have any further questions, please contact Provider Assistance at (312) 938-7340.

(This report is published as a service to the physicians of Illinois.) (11/6/92)



# Gag rule being enforced in Illinois

**COUNSELING:** Despite opposition from Illinois' Republican governor, family planning clinics receiving federal funds must comply with the ban on abortion counseling. By Kevin O'Brien

[ SPRINGFIELD ] Gov. Jim Edgar's opposition and a recent court hearing notwithstanding, Illinois family planning clinics that receive federal funds have been notified to comply immediately with the federal ban on abortion counseling.



Health Oct. 5 informed all Illinois agencies that receive Title X funds to "immediately implement the mandates of the federal government," IDPH spokesman Thomas J. Schafer told *Illinois Medicine*. Physicians practicing in such clinics have some leeway, however, to refer women to clinics that provide multiple

services – including abortion – if medically warranted.

"Governor Edgar is not enthusiastic about the gag rule and disagrees with the president on this issue," said Dan Egler, the governor's spokesman. Egler said the governor has been pro-choice since the mid-1970s. President Bush opposes abortion except when the mother's life is threatened or in cases of rape or incest.

Schafer said the U.S. Department of Health and Human Services denied Illinois' request to delay enforcement until Nov. 1 and directed the state to implement the federal rule immediately. He said the state requested extra time to issue new contracts to family planning agencies, publish a rule to administer the ban and set up compliance training sessions.

Instead, all family planning clinics receiving Title X funds were told to follow guidelines issued in May, when the gag rule was supposed to go into effect. Schafer said all the contracts have been recalled and agencies have been asked to pledge that they will enforce the mandate. New regulations were published in the *Illinois Register* Oct. 16.

An HHS spokesman said enforcement was ordered even though the Federal Circuit Court for the District of Columbia was to hear arguments Oct. 14 in an appeal challenging the ban. Federal District Court Judge Charles Richey Sept. 30 declined to issue a temporary restraining order halting enforcement pending appeal of his ruling. He ruled the regulations illegal because they were never released for public comment.

President Reagan ordered the ban in February 1988. Previous challenges that the rule was unconstitutional because it prevented low-income women from receiving information regarding the right to a legal procedure failed when the U.S. Supreme Court upheld the regulation on May 23, 1991. The American Medical Association objected to the decision on the grounds that it unduly interfered in the physician-patient relationship.

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*Physicians ... have some leeway, however, to refer women to clinics that provide multiple services – including abortion – if medically warranted.*

Congress passed a bill last year overturning the gag rule, but Bush vetoed it. To ward off a veto override, Bush issued an order instructing that "nothing in these regulations is to prevent a woman from receiving complete medical information about her condition from a physician."

Consequently, HHS issued guidelines March 20 stating that physicians practicing in such clinics may not counsel patients that abortion is an option unless it is medically necessary. Physicians may then refer patients to facilities that offer a broad range of prenatal care and social services, including abortion. However, such referrals must be based on medical considerations, and referral to facilities whose sole activity is providing abortions is precluded.

But the AMA said the president's order did not go far enough because most Title X facilities are staffed by non-physicians. Congress in September again passed legislation overturning the ban, but Bush again vetoed it. On Oct. 1, the Senate voted 73-26 to override the veto, but the House failed in its attempt to garner the two-thirds majority it needed to override.



# Are patients taking more responsibility for their own health?



**Stephen R. Humowiecki, M.D.**  
Family practice, Oak Park

I practice at the Wholistic Health Center of Oak Park. A lot of people who come there feel that they need to be primarily responsible for their health, so they come in more frequently for exams. They're exercising, trying to do stress management, trying to follow a healthy, non-American, low-fat, high-fiber diet. I think that that's very common. And people read and bring me articles before they ask questions.



**Jeffrey S. Royce, M.D.**  
Family practice, Rockford

Yes. I think the news media helps to scare people into the office a good deal. In my own practice, I demand that patients become responsible for their own health care. I insist on it. I think the days of the patient coming in the office saying, "You're the doctor, you make the decisions," have really gone by the wayside.



**Richard S. Katz, M.D.**  
Internal medicine, Highland Park

Certainly in my practice they are. My practice is in Highland Park, where patients are in general more affluent and more concerned with their health than [people are] in some of the other areas. Yes, they are coming in asking many more questions, and in most cases are more aware of what's going on, more educated. I think that translates into practicing more preventive care, coming to see the physician more often for health maintenance.



**Azeem M. Ahsan, D.O.**  
Family practice, Joliet

Unfortunately, the vast majority are still not coming in and asking the right questions, or giving the correct answers. They are still not very forthright about their drug use and are not as forthcoming as I would like them to be.

*Interviews by Anna Brown  
Photos by Michael Candee*

## MEMBERS IN THE NEWS



**Joseph L. Murphy, M.D.**, of Chicago, was recently named president of the American Board of Quality Assurance and Utilization Review Physicians. A diplomate

of the board since 1982, Dr. Murphy was elected to the Board of Directors and was first vice president in 1988. He has also served several years as chairman of the Credentials Committees.

Dr. Murphy, a board-certified internist and geriatrician, is section chief of general internal medicine at St. Joseph Hospital in Chicago and an assistant clinical professor of medicine at Northwestern University Medical School.

The University of Illinois College of Medicine at Peoria has named **Richard W. Carlson, M.D., Ph.D.**, of Peoria, chairman of the department of internal medicine.

Dr. Carlson is a fellow in the American College of Physicians and the American College of Chest Physicians, and is a founding member of the American College of Critical Care Medicine. He has published more than 250 articles and abstracts, and two books.

Dr. Carlson comes to the college from Wayne State University School of Medicine in Detroit, where he was pro-



CAROL T. POWERS/THE WHITE HOUSE

**ANTONIO RAMOS, M.D.** (left), of Winnetka, and his family were recently guests at the White House to receive an award as the 1991 Hispanic-American Family of the Year from Illinois. The award is given by a California-based foundation that honors models of family life and community service in seven states. Barbara Bush is the program's honorary chairwoman.

In addition to his general surgery practice, Dr. Antonio Ramos and Associates, Dr. Ramos is chairman of the Mexican-American Chamber of Commerce of Illinois.

fessor of medicine and chief of the Division of Pulmonary and Critical Care Medicine from 1983-92.

**Mitchell L. Rhodes, M.D.**, of Highland Park, Nov. 2 became executive vice president of the Council of Medical

Specialty Societies and secretary of the Accreditation Council for Continuing Medical Education.

The CMSS comprises 24 national medical specialty societies and provides staffing services for the ACCME, which accredits national providers of

continuing medical education. Dr. Rhodes, a specialist in pulmonary disease, most recently served as associate dean for clinical affairs at the University of Health Sciences/The Chicago Medical School in North Chicago.

**Suellyn S. Rossman, M.D.**, of Northbrook, is the Greater Chicago chairman of the American College of Allergy and Immunology annual fund-raising event, to be held Nov. 15. The event supports fellowships and clinical research and raises funds for community-based inner-city asthma programs.

Dr. Rossman, a board-certified allergist, is a diplomate of the American Board of Allergy and Immunology and the American Board of Internal Medicine, as well as treasurer of the Board of Certified Allergists of Greater Chicago.

The Illinois Chapter of the American Academy of Pediatrics recently named **James P. Paulissen, M.D.**, of West Chicago, Pediatrician of the Year. During his tenure as director of the Division of Family Health of the Illinois Department of Public Health, the first statewide regionalized perinatal program was developed. Dr. Paulissen also initiated the Early Periodic Screening Diagnosis and Treatment Program and the Women, Infants and Children Supplemental Nutrition Program. Dr. Paulissen also serves as the executive director of the DuPage County Health Department.



# Illinois Medicine

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## EDITORIAL

# Charity begins ... at the office

Charity care, for lack of a better term, is care a doctor provides to patients who cannot afford to pay for it. Each situation, like each patient, is unique. What is common across the profession is that doctors regularly provide care for which they know they will not be reimbursed.

In fact, outside of the ministry, it seems only the learned professions are committed to the concept of providing charity care – uncompensated care provided because it serves a greater good than the practitioner's pocketbook. (Try asking a plumber for some *pro bono* work.)

Most physicians do not publicize their charitable activities. And yet because the extent of medicine's work is largely unacknowledged, physicians too often are tagged with the blame for escalating health care costs.

There is a way that the doctors of Illinois can begin to make a significant difference in our state's indigent care.

Look at your practice. Do you regularly schedule charity patients? Do you provide charity care only for established patients when they fall on hard times financially? Do you limit the number of Medicaid patients your practice accepts? How does your receptionist respond to the new patient phone query, "Does the doctor accept the green card?"

Look at your hometown. How big is the need for charity care? Has the city's second largest plant just closed? Is the number of pregnant teenagers, elderly

citizens, homeless families growing? What about unmet need in your own ZIP code?

Look at your options. There are a number of ways you can begin to help without seeing patients. You can contribute to the United Way. You can write a check to the local clinic, to the homeless shelter, to your church's charitable programs. You can donate drug samples, and medical equipment to shelters or community clinics.

You can accept charity patients or referrals from clinics that provide charity care. You can make a private commitment, unannounced to anyone but your billing manager, to provide charity care to one new patient a week – or whatever number feels comfortable.

Finally, you could urge your county medical society to work to establish a free care clinic in your area.

Look at your calendar. The Illinois State Medical Society is sponsoring an important daylong seminar called "Indigent Care: What Works?" in Joliet on Nov. 20. At that seminar, representatives of medical societies and free clinics that have already undertaken this challenge will share their success stories, their caveats and their methods.

Charity may begin at home – but it's in our professional lives that it can have its greatest impact. The idea behind charity medical care is not to give until it hurts – it's to give so that someone else won't hurt.

## PRESIDENT'S LETTER

# Woeful waste weakens well-being

By Arvind K. Goyal, M.D.



*"Some research projects and surveys supported by public funds do not further public health interests in a practical fashion."*

A successful farmer was once asked by an agriculture student how he had become so rich. "It's a long story," the old man started, "and while I'm telling it, we may as well save some energy." And he put the lamp out. "There's no need to say anything more," the youth interrupted. "I understand now."

Waste and inefficiency in our health care system have contributed to rising costs at a time when we can least afford it. Some waste results from increasing regulation and interference by government regulation, rising expectations of our patients, and increasing demands by third-party payers of health care. Physicians' desire to protect themselves with extra tests, procedures and consultations, in case of a malpractice suit – "defensive medicine" – also adds to the bills in a substantial way.

Daily blood tests, chest x-rays, and continual heart monitoring as routine orders for every patient admitted to an intensive care unit add up those dollars quickly. Presurgical tests at hospitals and surgicenters ordered from a predetermined list are too much for some of our patients. A pregnancy test at a cost of \$30 ordered for a previously hysterectomized or postmenopausal female patient may actually be a disservice associated with "cookbook medicine." And don't forget that practice of brand-name prescribing when equally effective and cheaper generic medications are available.

Required pathological examination of all tissues removed in surgery, including scar tissue, circumcised preputial skin, normal-looking placental tissue, grossly identifiable "foreign bodies," and previously applied screws and pins removed from bones, serves only to generate unnecessary information, paper, and of course bills!

Increased bureaucratic paperwork, documentation and billing requirements by Medicare, Medicaid and other third parties not only raise costs, but also deter access because many providers cannot realistically meet those requirements and therefore choose not

to participate in those programs. In my practice, 60 percent to 70 percent of the paperwork is generated by the 25 percent of my patients covered by Medicare and Medicaid! Second opinions routinely required by some insurance companies even in simple and straightforward cases only double the cost of benefits. Medical directors and the ever-multiplying pool of administrative and marketing personnel hired by hospitals, insurance companies and HMOs increase their payroll while raising health care costs for everyone else.

Mandatory professional/peer review programs cost millions each year, dollars that can be better spent immunizing many children in need, for one example. At an annual federal expenditure of \$15 million per year, it remains doubtful if the work of Crescent Counties Foundation for Medical Care in Illinois has improved quality or utilization parameters. Utilization review programs by and on behalf of insurance companies and hospitals create yet another layer of bureaucracy, (those "middle men" all have to be paid too!) and increased physician and staff time spent on non-patient-care activities for questionable, if any, benefit. Worse, well-trained nurses are lured from nursing into some utilization review/management activities, exacerbating the nursing shortage!

Some research projects and surveys supported by public funds do not further public health interests in a practical fashion.

Lifestyle choices adopted by otherwise responsible adults – violence, illicit drug usage, alcoholism, cigarettes and unsafe sex – further add to the burden of preventable diseases and injuries, for which care is not cheap.

And required compliance with ever-increasing government regulation – OSHA, CLIA and the like – again raises the health care bill.

Whatever shape and size health care reform takes, we need to cut these and other wasteful habits and practices. We can't waste what we have, or don't have!





"Who was first?"

## GUEST EDITORIAL

# The failing tort system

**A**pologists for the tort system purport it to be the champion of otherwise hapless victims of medical malpractice. They claim it is the agent for redress of wrongs, redemption of losses, compensation for suffering and punishment of wrongdoers. This view, however, is a self-serving fiction by plaintiff attorneys. When we explore how the tort system has resolved malpractice issues, we find injury to the delivery of health services and corruption of the doctor-patient relationship. The system has added profoundly to medical costs while enriching opportunists.

Public expectations have been manipulated, achieving the exaggerated belief that medical diagnosis and treatment should be entirely risk-free. Moreover, the public has been led to believe that adverse outcomes should be perceived as someone's fault and thus merit compensatory awards. Consequently, incentives to invent blame are stimulated to achieve entitlement to compensation. However, when events are not glaring enough to provide "sure winners," those victims of adverse medical outcomes can be among the stranded.

Our society has been maneuvered into being more solicitous of a minority of personal injury claimants than of its servants who put themselves in harm's way. Consider what the tragic dead and maimed from the Vietnam War deserve in compensatory awards for their irreplaceable losses of health and life. For them, there is not enough money in our economic system to match the jackpots garnered by skilled personal injury lawyers. Moreover, those immoderate awards cheapen the lives of everyone who is left out.

The failure of the tort system impels us to examine alternatives. There have been effective experiences with "no-fault" solutions in other critical endeavors. For example, in the shipping and manufacturing industries, worker's and seaman's compensation systems have eliminated similar wasteful conditions in their laws. In like manner, economic losses secondary to adverse medical outcomes can lend themselves to inventory, from which we can determine compensation. Formulas and a system to reach just and

affordable compensations can be achieved through our society's democratic processes of dialogue, compromise and consensus.

Another category of injury requiring relief involves those losses that are neither material nor tangible. Monetary compensation for subjective suffering can mockingly miss the target of what may have been beyond price. Responses to this aspect of loss require a personal dimension. They involve delivery of concerned human attention, emotional support, comforting, and the therapeutic interventions needed to rebuild the lives of such casualties. Appropriate economic compensation may also be called for, to fund the services required to deliver this aspect of redress.

When harm has been caused by a physician's omissions or commissions, under circumstances where he or she could have responsibly chosen otherwise, justice commands that there be fair penalty to the wrongdoer. Justice includes aspects of redemption through discipline, censure, rehabilitation and re-education. The proper judgment scene for professional errors would be a court of professional peers. This tribunal would operate above self-interest, through both supervision by and accountability to the larger community.

Measured against a morality of consequences, our tort system is a failure. When it generously benefits only a minority of victims of adverse medical outcomes, it fails the larger number who are left out. When it causes clinically unneeded defensive medical procedures to be delivered as a bulwark against possible lawsuits, it adds billions of dollars to society's costs for medical services. Finally, the system fails by spreading economic liability risks without targeting for punishment those real agents of malpractice.

**Earl N. Solon, M.D.**, is a psychiatrist in Park Ridge and a member of the Illinois State Medical Society. **Thomas G. Baffes, M.D., J.D.**, is a cardiovascular surgeon and lawyer, now practicing health law with Pierce, Daley, Baffes & O'Sullivan in Chicago.

## GUEST EDITORIAL

# The ethics of managed care

**W**hile managed care has become a widely accepted method of controlling health care costs, physicians are struggling with emerging ethical issues surrounding this health care delivery system.

Slowly, physicians are coming to terms with the role they can play in controlling the escalating costs of health care. In fact, more and more employers are nudging employees into cost-effective managed care plans. Many families find the freedom from out-of-pocket expenses a great incentive to join a managed care plan. As a result, physicians see increasing numbers of established patients switching from indemnity plans to reduced-fee plans. At some point, getting on the managed care bandwagon becomes a matter of good economic sense.

Still, the overriding concern of the physician must always be for quality patient care. While many physicians have embraced the managed care system, they may face difficult choices between a patient's emotional and physical needs and economic incentives and disincentives.

Because physicians like to make decisions based on more information rather than less, the traditional practice of medicine likely resulted in overutilization of testing and technology. The new order is causing physicians to re-evaluate the need for routine tests and procedures. Doctors must ask, "How much information will I get from this test? How will it affect my patient's care? Can I get the same information with a lower-cost procedure?" This is managed care at its best – a healthy balance of care and costs that should result in the best treatment for the patient.

Some physicians, however, are concerned about the economics of managed care. In a traditional fee-for-service scenario, financial responsibility for treatment rests with the patient or his or her insurance company. Managed care, on the other hand, shifts the fiscal responsibility to the physician. The relationship between treatment and income is turned upside down – not ordering tests likely will generate more income to the physician through incentives from the payer. As a result, physicians are examining their motives for patient treatment.

The question of patient responsibility also arises. Because managed care removes fiscal responsibility from patients, it may also remove barriers they had for demanding the latest

and most expensive technology. In the traditional practice of medicine, doctors hold a bias toward action. Face-to-face with a patient's very real anxiety and fear, a physician may be reluctant to say that testing and/or treatment is not needed. While the physician's imperative is to take care of the physiological or emotional problem, the best treatment plan may entail no action. Physicians may find it difficult to say no to a patient, but

sometimes it is the morally and fiscally responsible thing to do.

Today's forward-thinking physicians will face many challenges in the realm of managed care. One avenue of relief is the independent practice association. An IPA gives physicians in private practice a way to contract with managed care payers, along with a sup-

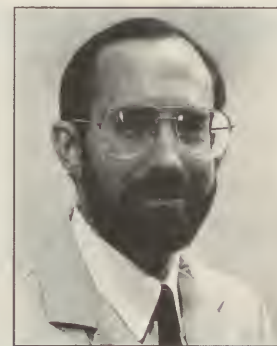
port system to deal with the issues of overutilization and underutilization, incentive pools and economic risk.

For example, the Michael Reese Doctors Group is an IPA network of 320 primary-care physicians and specialists serving 25,000 patients. Through the MRDG, member physicians have contracts with more than 25 HMOs and PPOs in the Chicago area. In addition to administrative support, the MRDG provides its physicians with quality assurance standards (including a peer-review committee), negotiates risk contracts and ensures consistent operating procedures within the group.

Members of the MRDG are no longer at risk for the costs of tests and procedures because the IPA manages the funds. Since the economies are the responsibility of the organization rather than the individual, the disincentives for ordering tests are lessened. On the other hand, institutional support is provided for the physician to "just say no" when no treatment is the best treatment possible.

Ideally, the balance of economic interests against the best interests of patients is fully realized in managed care. But economics cannot be the only factor – or even the primary factor – upon which patient-care decisions are based. Underutilization is just as worrisome as overutilization. Working to support the inevitable professional changes in physicians' practice styles, a well-run IPA can eliminate the difficult choice between economic survival and the good of the patient.

*Physicians may find it difficult to say no to a patient, but sometimes it is the morally and fiscally responsible thing to do.*



**David T. Wechter, M.D.**, an internist, is president of the Michael Reese Doctors Group and is a member of the Illinois State Medical Society.

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# IDPR inquiries require careful responses to avoid patient confidentiality conflicts

**DISCIPLINE:** Physicians should be aware of IDPR's inquiry and review process. By Edward F. Bruno

[ CHICAGO ] When the Illinois Department of Professional Regulation receives a report alleging professional misconduct or questioning a physician's ability to practice, an inquiry and review process begins. That process often triggers the following questions:

• *Am I required to cooperate with a department inquiry?*

Failure to furnish the department with "relevant information, legally requested" is a basis for disciplinary action. However, it is permissible for the physician to wait a reasonable amount of time to confer with counsel – for example, to determine whether the request is legal.

• *Can I attend a hearing or conference but "take the Fifth"?*

IDPR cannot compel testimony. However, Illinois courts have held that refusal to testify can be held against the physician and, along with other evidence, can be considered in determining whether the law was violated.

• *Can the department gain access to medical records? What about patient confidentiality?*

A department investigator does not automatically have authority to review records, nor can a physician be required to disclose confidential patient information verbally unless the patient consents. However, the Medical Disciplinary Board may subpoena medical records, provided that patient identifiers are

removed. Before allowing access, physicians should always require written patient authorization or a subpoena from the Medical Disciplinary Board.

• *If I know I made a mistake, should I admit it?*

If rehabilitation or remedial education is an issue, admitting knowledge of wrongdoing is essential to show that remediation has occurred. However, if choosing a course of treatment was a difficult judgment call that resulted in a poor outcome, an imprecise admission might form a basis for licensure sanction, when it might not otherwise exist. The question should be decided only after carefully considering the case. Even honest contrition may not have a desirable result.

• *If I didn't do anything wrong, why should I worry about an investigation?*

Parties to conversations may remember those conversations differently. If an investigator misunderstands an explanation or if an answer is recorded incorrectly in interview notes, the case becomes infinitely more difficult to resolve favorably. What may have started as a simple case may then involve the physician's professional integrity and fitness to retain a license. Every lawyer has a horror story about trying to retract a statement that was never made. Legal representation helps prevent pitting the physician's memory against the inves-

tigative file.

• *Should I let an investigator come to my office to "have a look around"?*

The disciplinary board may issue an order authorizing an investigator to enter the premises during business hours. Such an order, without a subpoena, does not authorize inspection of the business, or personnel or medical records. The investigator should show identification and a copy of the order. Orders expire five days after issuance, so physicians should check the date of issuance.

• *What should I do if an investigator cannot produce identification?*

Since all medical investigators are issued identification, anyone failing to produce it should be presumed to be an imposter. If identification appears questionable, contact the department for verification before proceeding.

• *Should I answer telephone inquiries by department personnel?*

Unless the physician recognizes the caller's voice and has previously determined the caller's proper authority to receive information, an attempt to cooperate could violate patient confidentiality. Even if confidential information is not discussed, avoid telephone conferences with department personnel. Simple disciplinary matters may easily become more complex as a result of misunderstood or misremembered telephone conversations.

• *What should I do if I am instructed to produce certain records to be picked up by the department?*

Any time the department asks for records – whether in person or by phone, and regardless of the caller's official position – the physician should probably seek legal advice. In general, however, whether the caller is the agency director or a newly hired trainee, the physician's first responsibility is to the patient. Without a release or subpoena, no records should be produced.

Every physician is responsible for cooperating with officials responsible for insuring the public's protection, but both the physician and the department have a duty to act fairly and honestly to further this goal. The Medical Practice Act of 1987 contains many safeguards to protect physicians and their patients from unreasonable intrusion into the physician-patient relationship. The safeguards are an implicit recognition of the essential privacy in such a relationship. Physicians who take advantage of every safeguard are merely acting prudently, since their professional health, as well as their patients' well-being, is at stake. ■

*Editor's note: Edward F. Bruno served as counsel and chief hearing officer for the Illinois Medical Disciplinary Board. He is now in private practice with the law firm Bruno and Weiner in Chicago.*

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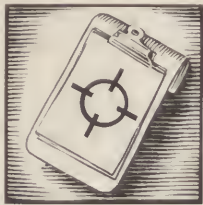


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Case in Point  
explores  
gastric  
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PAGE 10

# ISMIE Update

Reporting  
endorsement  
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schedule  
lengthened

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## New brochures explore breast implant liability, retiring physicians' insurance options

**BROCHURES:** The Exchange highlights policy options for retiring physicians and explains silicone breast implant liability. By Gina Kimmey

To meet the needs of its insureds, the Illinois State Medical Inter-Insurance Exchange has developed two new brochures. "Exploring Liability Issues - Silicone Gel-Filled Breast Implants" and "Policy Options for Retiring Physicians" address concerns recently expressed by policyholders.

"We have always encouraged policyholders to contact the Exchange with any questions or concerns they may have regarding their policy," said Harold L. Jensen, M.D., chairman of the Exchange Board of Governors. "We have rededicated ourselves to providing first-rate service to our policyholders, and these brochures are part of our efforts to give a timely response to their concerns."

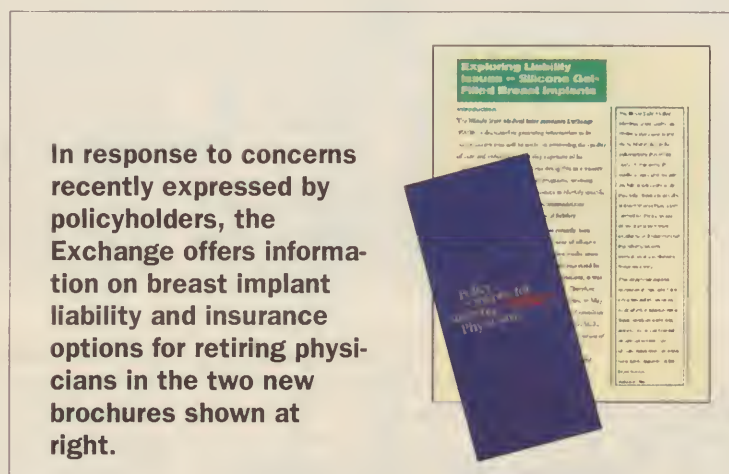
After realizing there was a strong need for such information, the Plastic Surgery Subcommittee, which met in May, developed the brochure on breast implants. "This brochure addresses some of the most common questions and concerns of our policyholders who are involved with breast implant surgery," said Jere E. Freidheim, M.D., chairman of the Exchange's Risk Management Committee and chairman of the Illinois State Medical Society Board of Trustees. "The issues surrounding silicone breast implants are still new, and the medical facts are still emerging. Our policyholders expressed a need for some guidance, and the subcommittee did an excellent job with this brochure."

**THE BROCHURE EXPLAINS** the rules regarding implants before, during and after the U.S. Food and Drug Administration's moratorium earlier this year. The standard of care has changed drastically since the moratorium, and the brochure lists the specific requirements delineated for

physicians who continue to perform silicone gel-filled breast implant surgery. The brochure also explains conditions and procedures for implant removals, stressing physician-patient communication in explaining a recommended course of treatment and providing information to help the patient make an informed decision. Physicians are advised to keep well-documented records. When documenting care, physicians should be sure their clinical decision-making process is clearly outlined and the patient's understanding is well documented.

A special unit dealing specifically with breast implant liability claims can be reached by calling (312) 782-2749, ext. 2474.

"Policy Options for Retiring Physicians" is a comprehensive



guide to help Exchange physicians select appropriate insurance coverage for their retirement. Recognizing the importance of retirement planning, the Exchange offers several policy options, depending on whether retirement from medi-

cal practice is complete or partial.

The Exchange policy's definition of retirement is the "conclusion of and complete withdrawal from one's working or professional career as a physician." Physicians retiring from

the practice of medicine should cancel their claims-made policies. Coverage ceases when the policy is terminated. However, the brochure explains how physicians can protect themselves from claims made after policy termination by securing a reporting endorsement or tail coverage. This option is available free of charge to physicians who are age 55 or older, have been insured with the Exchange for a minimum of five consecutive years, and meet the Exchange's definition of retirement. The brochure also explains how, under certain conditions, policyholders are allowed to provide medical care in a free clinic or serve in an administrative capacity and still qualify for free tail coverage.

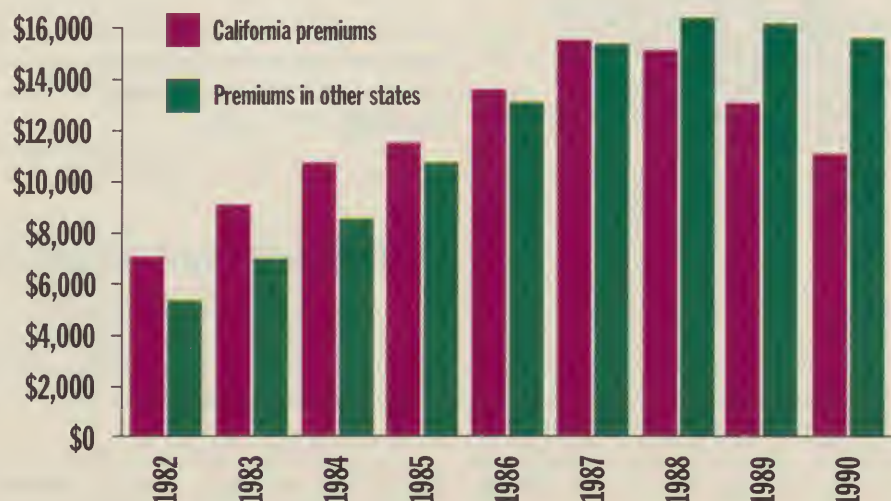
**ANOTHER INSURANCE OPTION** is available to physicians aged 55 or older who have not been insured with the Exchange for five or more consecutive years. These physicians may earn partial credit toward a tail premium, equal to one-sixtieth of the total premium for each consecutive calendar month, to the point of termination, that the physician was insured with the Exchange. Tail premiums are based on rating class, territory and limits of liability in effect at the time of policy cancellation. The brochure discusses ways retiring physicians can lower their tail premium.

For physicians who are not ready to completely retire or who are uncertain of their plans, several options are explained. "Retired, not in practice" allows physicians to retire from clinical practice but occasionally treat friends or family, for no remuneration. "No clinical practice" allows physicians to begin an administrative research position as their only medical practice activity. Finally, the Exchange offers suspended coverage, which requires physicians to deactivate their policies for a minimum of one month or a maximum of 12 consecutive months.

Physicians who have reviewed these brochures but still have questions or concerns may contact the Exchange Monday through Friday, 8:30 a.m. to 4:45 p.m., at (312) 782-2749 or (800) 782-ISMS.

## California's reforms cut liability costs

California's aggressive tort reforms appear to have been effective in stemming the growth in professional liability premiums, the AMA Center for Health Policy Research reported. While the average premium was 27 percent higher in California than other states in 1984, it was 30 percent lower in 1990, after the reforms had been in effect for five years. The reforms include a \$250,000 cap on noneconomic damages, periodic payments of damages over \$50,000 and limits on contingency fees.



Source: American Medical Association Center for Health Policy Research. Reprinted from *This Week*.



# Case in Point

By Tony Sullivan

## Case #1

### Presenting complaint and initial diagnosis:

A 5-foot-7-inch, 238-pound, 38-year-old woman presented to a physician for gastric bypass surgery. She had weighed more than 230 pounds for several years and had failed to lose weight on diets. The physician performed a gastric bypass and retrocolic gastrojejunostomy. The surgery went without incident.



**The case in brief:** During the ensuing months, the patient experienced complications due to stricture of the stomal site necessitating further surgery and removal of the Marlex band. Continued problems during the following

months prompted the physician to perform a biliopancreatic bypass and distal gastric resection. During this procedure, the physician anastomosed the small intestine about 4 cm from the start of the cecum.

During the next three months, the patient experienced a 70-pound weight loss and complained of vomiting, diarrhea, constipation and abdominal pain. He was subsequently admitted to a hospital by another physician, who performed an exploratory laparotomy, reversal of the biliopancreatic bypass with a Roux-en-Y, and a gastrojejunostomy. The patient's condition and weight stabilized, but he could no longer tolerate certain foods or drink liquids with meals.

**The resulting claim:** The patient sued the first physician for failing to recognize and diagnose ulcers and obstructed vertical banded gastroplasty and for performing an improper surgical technique.

**The outcome of the claim:** The case was settled for \$490,000.

**The points these cases make:** These cases illustrate the inherent difficulties of

performing surgery on morbidly obese patients and the many common complications than can occur with bariatric surgery, said Alec Hood, M.D., a general surgeon from McLeansboro.

Gastric reduction operations – more often referred to as gastric partitioning or gastric bypass – are commonly performed surgical procedures primarily designed to help morbidly obese patients lose weight, Dr. Hood explained. The procedure involves surgically creating a very small stomach reservoir with a capacity of about 1 ounce. The procedure produces weight loss by decreasing the amount and volume of food a person can consume.

These cases illustrate several risk management steps that physicians should heed when considering or performing gastric reduction surgery. One involves close monitoring to ensure that complications do not occur either in the immediate or delayed postoperative period. Most complications develop soon after the procedure, Dr. Hood said. In general, physicians should follow these patients quite closely for complications, as well as metabolic problems and weight loss, for at least 24 months.

Another step involves conducting a psychologic screening on patients before the procedure. This is a critical risk management action, Dr. Hood said. Many morbidly obese patients have emotional problems, and physicians need to keep this in mind when considering whether to accept these patients as suitable candidates for surgery.

Preoperative psychologic screenings can identify these at-risk patients and can reveal whether they are emotionally ready to accept the eating limitation they will experience after the surgery, according to Dr. Hood. Preoperative metabolic assessments should also be conducted to rule out previously undiagnosed dia-

betes, thyroid problems, adrenal problems or other endocrine conditions that may be causing or contributing to the patient's obesity, Dr. Hood advised.

Physicians should also consider the patient's height-to-weight ratio, Dr. Hood said. A patient must be at least 100 pounds over ideal body weight to be a candidate. This is the universally accepted definition of morbid obesity, and it is a strict criterion, Dr. Hood emphasized. Surgeons are at risk for liability if they perform the procedure on anyone who does not meet this criterion.

As in Case No. 2, use of a Marlex band to prevent the patient's stoma from stretching was common practice in vertical band gastroplasty conducted in the early to mid-1980s, Dr. Hood said. "Unless the surgeon made a technical error in placing the piece of Marlex too tightly around the stoma, that alone should not have caused the ensuing complications. Stomal stricture is a recognized complication in many of these techniques and doesn't always imply surgical error," he said.

A clear problem in this case occurred in the subsequent procedure, when the physician linked the small intestine to the large intestine only 4 cm from the cecum, Dr. Hood said. The ideal placement is 40-50 cm away, to avoid bypassing too much of the absorptive surface of the intestines.

"The complication rate on surgery involving obese patients is fairly high," Dr. Hood said. "You have to use meticulous surgical technique in dealing with even the most simple of these cases because these patients are very difficult to operate on."

## MALPRACTICE ROUNDUP

### Tainted blood supplies lead to AIDS cases

*Medical Liability Monitor* reports on several cases stemming from blood supplies tainted by HIV. A New York man who claimed he was not warned of the risks of using donated blood instead of blood from the hospital's own supply has settled his case against the hospital and a physician. The man apparently acquired AIDS after receiving blood donated by a friend who later died of AIDS. The man said a nurse told him it was safer to use blood from friends and relatives. He contended he did not understand the risks and doctors should have insisted he use hospital blood.

A mother whose baby died of AIDS as a result of a 1985 blood transfusion infected with HIV has won the right to obtain medical information about the blood donor. The *Monitor* reports that the woman claimed the Red Cross was negligent in supplying the blood. A federal appeals court in Richmond, Va., ruled that the court, not the mother, will get the information, but she will be given certain details about what happened during the donor screening process.

And in Colorado, a jury awarded \$6.7 million to a woman who contracted AIDS from a 1983 blood transfusion, unaware that she died the day before the award was made. Attorney for the United Blood Services of Albuquerque said the blood bank will appeal on the grounds the judge should have declared a mistrial after learning the plaintiff had died.

### Physician liable for patient suicide

An emergency room physician who refused to admit a patient to the hospital for insurance reasons was later held liable for the patient's suicide. As reported in *The Malpractice Reporter*, the doctor was told the patient was being treated for depression on an outpatient basis by his family physician. After diagnosing depression and an overdose of sleeping pills, the doctor decided to admit the patient to the psychiatric unit for 72 hours.

The hospital could not verify that the patient's insurance would cover psychi-

atric care and required a \$400 deposit that the family could not pay. While the doctor had the authority to waive the deposit requirement in the event of a true emergency, he decided not to exercise the waiver. Fifteen hours later the patient committed suicide.

The doctor was aware of the patient's depression and overdose of sleeping pills, and he knew this was a dangerous combination that created a suicide risk. The court ruled that the doctor's conduct fell below the appropriate standard of care and was a substantial factor in the death.

### Grandchildren can't sue

As reported in *Ohio Medicine*, the Ohio Supreme Court ruled that grandchildren of women who took a drug to prevent miscarriages cannot sue the drug manufacturer for their own birth defects. A couple whose son was born 11 weeks premature with cerebral palsy claimed their son's birth defects resulted from injuries to his mother's reproductive organs, caused by a drug his grandmother took while pregnant.

The court ruled 4-3 that because of the remoteness in time and causation, the couple did not have an independent cause of action.

### AMA reports most physicians practice risk management

The American Medical Association reported in *This Week* that virtually all respondents to an AMA survey use some form of risk management, including physician-patient communications, recordkeeping systems and clinical standards. More than three-fourths said they have participated in risk management education.

Of responding physicians, 92 percent said they practice risk management to improve patient safety and 82.8 percent to avoid malpractice claims. Requirements of hospitals, employers or insurance carriers, and state laws were only secondarily important.



## Exchange lengthens reporting endorsement payment schedule

[ CHICAGO ] The Illinois State Medical Inter-Insurance Exchange announced a new benefit for physicians requesting reporting endorsements, sometimes called tail coverage. Policyholders now have an extra 25 days to pay their reporting endorsement premiums.

The extended payment schedule on reporting endorsements will help ease the hassles involved in making significant practice changes for physicians who relocate, change their carrier or redefine the parameters of their practice, said Harold L. Jensen, M.D., chairman of the Exchange Board of Governors. The billing period has been increased from 25 to 50 days because the Exchange has found that 25 days is not always enough time for physicians in a state of transition to return their premiums on time.

Dr. Jensen noted several common rea-

sons why reporting endorsement payment might be late. The physician may pay a portion of the tail, and his or her former employer — an ISMIE insured — might pay the balance, he said. Or, the physician's new employer might agree to pay the balance. Often an invoice might make the rounds of administrative offices before payment is authorized and a check cut.

Finally, if the physician is in the process of moving, correspondence might not be forwarded on a timely basis, Dr.

Jensen said.

Physicians should remember, however, that policies, including reporting endorsements, may be canceled if not paid on time. Each policy is reviewed to determine if there is a valid reason for accepting a late payment, and if the Exchange does not accept the payment, it will be refunded and the tail coverage denied.

The new reporting endorsement payment schedule will now correspond to the payment schedules of other premi-

ums, which are billed quarterly. For the remainder of the 1992-93 policy year, policies will be terminated if payments have not been received by Jan. 11, 1993, and April 9, 1993. Payments are due on the first of those months, with a brief grace period. Over the next two years, that grace period will gradually disappear until coverage will be terminated if payment is not received by the first of the month.

Physicians who have questions about reporting endorsements and the new payment schedule should contact the Exchange Underwriting Division at (312) 782-1654 or (800) 782-ISMS. ■

### EXCHANGE Q & A

**Q. What is an incident, and what does the Exchange consider reportable as an incident?**

A. Incidents are considered to be "potential claims." Like claims and lawsuits, incidents should be reported to the Exchange as quickly as possible to allow Exchange claims analysts to investigate the situation and gather information while it is still memorable. Following this procedure actually protects physicians, since incidents are the seeds of malpractice lawsuits. The Exchange requires reporting of the following incidents, which have shown a high probability of developing into claims or lawsuits:

- Death;
- Loss of a major body part;
- Permanent or partial impairment of a bodily function;
- Loss or impairment of any of the five senses;
- Severe disfigurement or paralysis;
- Serious billing complaints;
- Any rumor or indication of a problem from any source;
- Any treatment complication, even if anticipated;
- Any injury reasonably likely to result in a claim.

The reporting of an incident does not affect your policy in any way.

**Q. I have a policy with the Exchange to cover my moonlighting activities while I participate in a residency-fellowship program. How will completing the program affect my policy?**

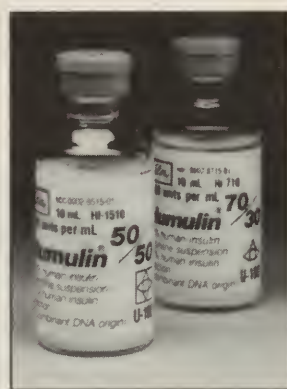
A. Your policy was written specifically for your moonlighting activities. Those who wish to continue coverage with the Exchange after a residency-fellowship must furnish information regarding their new activities to assure appropriate coverage. ■



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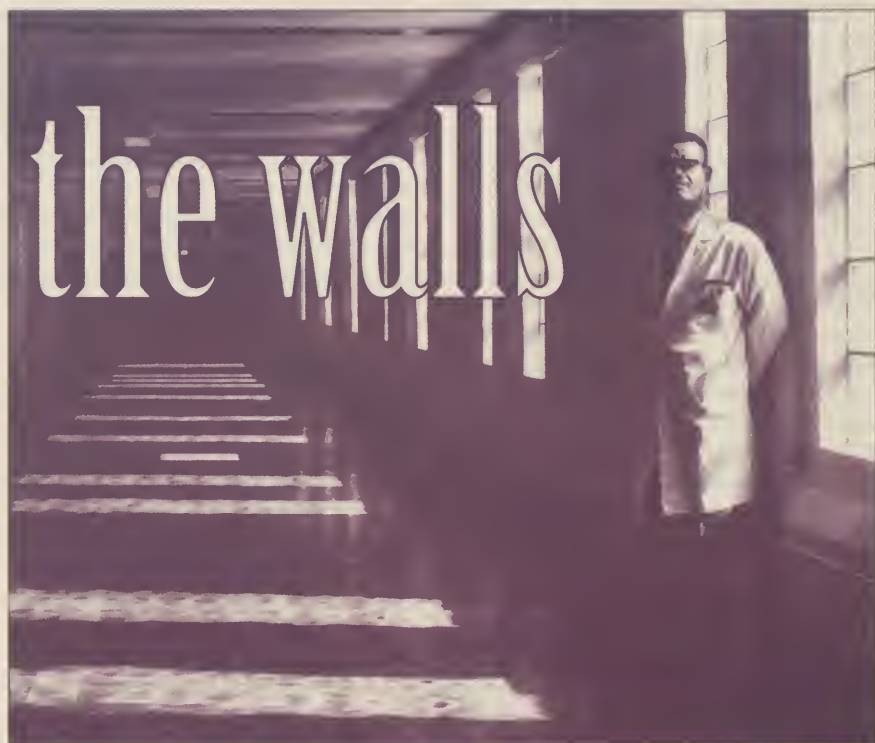
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## CORRECTIONAL HEALTH CARE

# Healing behind the walls

*At maximum-security Stateville Correctional Center in Joliet, medical director Art Brewer, M.D., sees his main role as protecting the public's health.*



BY ANNA BROWN

PHOTOS BY TERRY VITACCO

**A**n inmate tried to hit me once with a cane – that's all," said Art Brewer, M.D., Stateville Correctional Center medical director, describing the only incident in his eight-year correctional system career in which he felt threatened by a patient.

"Murders do occur here – inmates murder other inmates. If you're in the wrong place at the wrong time, if you're a witness ..."

But Dr. Brewer's mission is not to intimidate other physicians. He strives to debunk the myths about correctional health, myths he himself once believed.

"There is the perception that correctional health care is dangerous," he said, "but actually, health care in general is a pretty dangerous profession. Some areas are more dangerous than others. Emergency room physicians, for example, are in a vulnerable position, as are those who work in mental health. But [prison] health care people are rarely involved in incidents where they are hurt. The inmates know we are here to help them."

**FOUNDED IN 1925**, Stateville Correctional Center in Joliet is a maximum-security state penitentiary housing 2,100 male prisoners. Surrounded by a 33-foot wall with guard towers, the prison boasts the largest cell-house in the world – Unit B – with 580 cells in one building.

The medical unit, located just off the tunnel behind Gate 2, is staffed by three full-time physicians, including Dr. Brewer, and contains a 22-bed infirmary, a 24-hour emergency room, examination rooms and a dental unit. Although laboratory facilities are off-site, laboratory results are obtained within 24 hours. The pharmacy was recently moved off-site to serve several other institutions, Dr. Brewer said.

Physicians, nurses and medical technicians see about 200 patients daily between 8 a.m. and 8 p.m., Mon-

day through Friday. Both a physician and a nurse are on call 24 hours a day. Surgery is the only medical service not performed at the full-service ambulatory facility. Approximately once a week physician consultants conduct specialty clinics. Specialists who often visit the facility include a general surgeon, an ophthalmologist, an optometrist, a urologist, an orthopedic surgeon and an infectious disease specialist. X-rays are also taken and read on-site.

In addition to specialty consultants, Stateville employs three psychiatrists, a psychologist and social workers who tackle all aspects of patient mental illness.

**THE PURPOSE OF PRISON** medical facilities, some of which have been accredited by the Joint Commission on Accreditation of Health Care Organizations, is to treat "any and all medical problems of inmates," said Ronald Shansky, M.D., the 10-year medical director of the Illinois Department of Corrections. Dr. Shansky has been hailed as an innovator who turned around a correctional health system plagued by lawsuits and made it one of the best in the country.

"We were the first prison system in the country to have a prison medical unit accredited by the JCAHO," he said, referring to Danville Correctional Center, accredited in 1988. Dr. Shansky is also responsible for implementing statewide quality assurance measures, and he wrote a manual on his planned transition to continuous quality improvement, a tenet adopted by the JCAHO in 1991.

"Failure to provide health care to incarcerated people is a violation of their civil rights," Dr. Brewer said. "It is thought to be cruel and unusual punishment. That has been the basis for providing health care for inmates, not that people just thought it would be nice. That's the reality."

During his tenure, Dr. Shansky, a board-certified



## CORRECTIONAL HEALTH CARE

internist with a master's degree in public health, established chronic illness clinics at every Illinois prison, instituted AIDS education programs, and helped make Illinois home to the only U.S. Centers for Disease Control-funded study of seroprevalence and incidences of HIV and hepatitis B.

"Physicians play a critical role in prisons as leaders working to form a comprehensive medical team," he said. "Physicians find working in prisons very rewarding, and they can document the results of their work." Dr. Shansky said prison medical work offers the benefits of regular hours, easy follow-up, and no malpractice insurance, since the state indemnifies correctional medical care.

"It's much safer than walking down the street," Dr. Shansky added. "There are no weapons, and physicians tend to use their instinctive discretion. Assault is very rare because physicians are providing a valid service. In fact, we feel physicians have an impact beyond medicine in that the inmates feel respected and in turn respect others."

Dr. Shansky introduced Dr. Brewer to Stateville in October 1988. At the time, Dr. Brewer had been working at Cook County Jail to fulfill a National Health Service scholarship requirement for recipients to work in areas in need of primary care physicians. He earned his medical degree from Washington University Medical School in St. Louis and served his residency at George Washington Hospital in Washington, D.C.

"When I was at George Washington, I never even had a patient who was arrested," Dr. Brewer said. "But I found there was a lot of opportunity [in correctional health] and a lot of work to be done. It is personally rewarding, and I have been fortunate."

**AS HE WALKS** the halls of his medical unit, it's clear that Dr. Brewer is in charge; he stops to consult with nurses, med techs and inmates, all of whom have questions for him. When Dr. Brewer walks from his office in the administrative section of the unit to the infirmary, he encounters a series of locked metal security doors, each requiring a separate key. The main door to the infirmary is manned by two officers who joke with him as he rummages through his huge ring of keys. Working inmates, called porters, are everywhere with brooms, mops and floor polishers. Dr. Brewer is careful to address each one as "Mr."

"If you can't function without being able to go anywhere you want to go when you want to go, you can't function in a correctional center," he said. He noted that every room in the medical unit has a window, including offices, examination rooms and restrooms. "We have to sacrifice privacy for security."

Once inside the infirmary, Dr. Brewer surveys the cells that line the hall. The infirmary houses several isolation cells intended for active tuberculosis patients. At State-

ville, there are currently no active cases of TB, and the cells are filled instead with inmates classified "extremely high risk for escape." Further down the hall are the mental health cells, housing new mentally ill inmates who are being evaluated to see if they are fit to remain at Stateville.

"If someone has a chronic mental illness and we can maintain him at Stateville, we will," Dr. Brewer said.

Inmate Gino Jude, who came to the medical unit from a work release program and is scheduled to be released this month, said he had no complaints about his medical care. He is one of the infirmary's short-term patients and is allowed more freedom to leave his cell. "I've been [in the infirmary] five months now, and I came here in really bad shape. I was bedridden and couldn't walk, and I was having seizures."

If infirmary patients need immediate medical attention, they touch a switch, and a nurse or med tech will come. "The doctors also make rounds every day," Jude said.

Another inmate, Robert Triplett, has spent a considerably longer time in the infirmary. Now in his 70s, Triplett is serving a sentence of 25 to 50 years, and has been at Stateville for 15 years. He most likely will remain in the infirmary, since he is epileptic and his leg was amputated in 1982. He said he was "promised a prosthesis" and that his care "could be better."

Dr. Brewer said Triplett did have a prosthesis, which allowed him to walk with a walker. Unfortunately, he fell and broke his hip when he attempted to slap a nurse who tried to give him a bath.

*Inmate Robert Triplett has been at Stateville for 15 years. Due to chronic health problems, he most likely will stay in the infirmary for the remainder of his 25- to 50-year sentence.*



*(Continued on next page)*



*Failure to provide health care to incarcerated people is a violation of their civil rights. It is thought to be cruel and unusual punishment. That has been the basis for providing health care for inmates, not that people just thought it would be nice. That's the reality.*

ART BREWER, M.D.  
STATEVILLE CORRECTIONAL CENTER  
MEDICAL DIRECTOR



## CORRECTIONAL HEALTH CARE

**Healing behind the walls***(Continued from page 13)*

Despite his complaints, Triplett did acknowledge that his environment had improved. Prior to 1989 when the new medical unit opened, Triplett and other sick inmates were housed in a less modern, unairconditioned medical complex.

**WHEN ASKED THE MAJOR** health issues he has found at Stateville, Dr. Brewer cited asthma as the No. 1 health problem among inmates. Dr. Shansky also listed tuberculosis, HIV and hepatitis B as the other major chronic illnesses found in the Illinois prison system.

"HIV is a problem," Dr. Brewer said. "We've made a lot of progress in education."

Dr. Brewer said when he first arrived at Stateville, inmates refused to live with an AIDS patient. "They said they wouldn't let him back in [the cellhouse], that they would kill him."

Because of prison and community education efforts, Dr. Brewer said inmates now accept AIDS patients within the general population. "We still have a long way to go, but so does the community," he said.

Dr. Brewer considers protecting the public health to be his primary role. The average length of prison terms is three years, although many prisoners are there for much longer, he said. The inmates return to the community and affect the health of society in general.

"One of the good things about practicing here is that a lot of inmates are here for a long time," he said. "You really can do good primary care here. You know where they live, you know what they eat. In the community,



you don't really know what your patients' lives are like. It's easier for us, because we're here too." ■

*The Illinois State Medical Society and The Illinois State Medical Inter-Insurance Exchange present*

# Indigent care: What works?

## A conference on free clinics and other indigent care alternatives

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**P**hysicians, business and community leaders, religious groups and hospitals, among others, are working together in communities throughout Illinois to extend access to health care for those in need. One visible and valuable result of these efforts has been the creation of several free clinics where those without access to other sources can receive free medical care for themselves and their families.

**\$25 cost sharing fee is for continental breakfast, luncheon and materials. No charge for medical students and residents.**

**For registration information contact the Illinois State Medical Society Field Services Department at (312) 782-1654 or (800) 782-ISMS, ext. 1150. If you need hotel accommodations for Thursday night, November 19, please contact the Holiday Inn-Joliet directly at (815) 729-2000.**





## Rockford hospital opens poison control center

**POISON CONTROL:** SwedishAmerican Hospital takes on poison control services for northern and central Illinois. By Anna Brown

[ ROCKFORD ] SwedishAmerican Hospital in Rockford opened Illinois' third Regional Poison Resources Center Oct. 19, replacing Pekin Hospital, which discontinued service Nov. 1, 1991. SwedishAmerican will serve 32 counties in northern and central Illinois.

The hospital volunteered to staff the poison control center after the state conducted a search to replace the Pekin facility, said Julie Radlund, coordinator for the Regional Poison Resource Center and pediatric services at SwedishAmerican. "It is important for SwedishAmerican to give back to the community," she said. "We have a strong pediatrics department, and since 90 percent of calls [to the poison control centers] come from pediatric patients, we felt strongly that we should operate the center."

The hospital accepts poison control calls 24 hours a day, seven days a week, and serves a population of about 1.7 million. Radlund stressed that the toll-free service is intended for physicians and hospitals as well as the public.

During the year before the SwedishAmerican center opened, St. John's Hospital in Springfield had been handling all calls for southern, northern and central Illinois, Radlund said. In addition to SwedishAmerican and St. John's, Rush-Presbyterian-St. Luke's Medical Center in Chicago serves Cook County and northeastern Illinois. The three centers provide acute poison information, product identification, poison identification and referral services. According to the Illinois Department of Public Health, Illinois poison control centers handled 85,000 calls in 1991.

Although SwedishAmerican has already received calls, Radlund predicted the volume of calls will increase as the

region becomes more aware of the center's presence. "We sent announcements to all media sources in each of the 32 counties," she said. The next step will be to contact all physicians and hospitals in the region. "It takes a long time to reach all of these counties," she said.

The SwedishAmerican phone line is staffed by registered nurses trained in poison control techniques, with the med-

ical director and co-medical director, both physicians, on call 24 hours a day, Radlund said. Staffers have access to a data base that provides information on 5 million chemicals and more than 200,000 products and drugs. The center follows up on each call, contacting callers after one hour, four hours, 12 hours and 24 hours, depending on the case.

Calls have been prompted by a child who "got into a can of Mace," a child who was bitten by a gerbil, and a child who ate Ex Lax, Radlund said.

The program is completely funded by SwedishAmerican and receives no state financial support, Radlund said.

Illinois first designated poison control centers in the mid-1970s, under terms of the Emergency Services Act. The state has since maintained three poison control centers, except for time between designations.

Physicians, hospitals and the public may contact the Swedish American Hospital Northern and Central Illinois Regional Poison Resource Center at (800) 543-2022. Contact the Chicago and Northeastern Illinois Regional Poison Resource Center, operated by Rush, at (800) 942-5969, and the Central and Southern Illinois Regional Poison Resource Center, operated by St. John's, at (800) 252-2022. ■

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The services, staff and leadership of the Illinois State Medical Society and the Illinois State Medical Inter-Insurance Exchange are as near as your phone. Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654. Both the Society and the Exchange phone lines are open from 8:30 a.m. to 4:45 p.m. Monday through Friday; during nonbusiness hours the night line can record brief messages.

In addition, ISMS President Arvind K. Goyal, M.D., is available for membership calls the first Wednesday of every month. Use the toll-free or Chicago number above and ask for extension 1333. ■



# New women's health specialty debated at Chicago conference

**SPECIALTY:** Conference reviews possible curriculum and practice areas of proposed specialty. By Kevin O'Brien

[ CHICAGO ] A patient at a Chicago clinic established exclusively for women echoed an increasingly common theme.

"I come here because of the comfort level," said Maureen McCreery, who talked with a reporter at Women's Health Resources, a clinic affiliated with Illinois Masonic Medical Center in Chicago's fashionable north Lincoln Park neighborhood. "There's an emphasis on me as a woman, not just a patient. It's not only the medical part of it, but a concern for [the other parts] of your life, whether that be social or emotional."

Whether to institutionalize McCreery's experience by establishing a women's health specialty was the subject of a recent national conference of 300 physicians, nurses, academics, and women's health and community health advocates.

The Oct. 15-17 conference, "Reframing Women's Health: Multi-disciplinary Research and Practice," featured intensive panel presentations and workshops covering not just whether to establish such a specialty, but what the practice and curriculum should be. It explored if a women's health specialty

could more effectively address women's health care issues.

"Over the past several years, nobody could miss the continuing flow of stories about problems in women's health care that are due to the fact that we don't know enough, that an awful lot of research that physicians depend on to help them and their patients make health care decisions just doesn't exist," said Alice J. Dan, Ph.D., director of the University of Illinois at Chicago's Center for Research on Women and Gender, which hosted the conference.

Dr. Dan said the fact that most research into heart disease was done on male subjects, even though heart disease is the leading cause of death of women, is the example most often cited for establishing a women's health specialty. But she noted the paucity of research into other health problems of women, such as depression

and violence on women, provides further evidence of the need to study women's health issues more intensively.

"We need a home of our own - to steal from Virginia Woolf," said Karen Johnson, M.D., assistant clinical profes-

*"There is no existing medical specialty that is devoted exclusively to the comprehensive care of women. As a result, health care for women is unnecessarily fragmented, costly and, in fact, often incomplete."*

KAREN JOHNSON, M.D.



WM. DANIELS/THE PHOTO PARTNERS

Alice J. Dan, Ph.D. (left), is executive director of the UIC Center for Research on Women and Gender, which hosted the recent conference on a proposed women's health care specialty. Wendy Foster, M.D. (above left), examines Wendy Newsome of Justice at Chicago's Women's Health Resources Clinic.

sor of psychiatry at the University of California at San Francisco and a leading advocate of an interdisciplinary specialty in women's health.

"Medicine is based on a male paradigm," said Dr. Johnson, who framed much of the discussion during the opening session of the conference. "There is no existing medical specialty that is devoted exclusively to the comprehensive care of women. As a result, health care for women is unnecessarily fragmented, costly and, in fact, often incomplete."

Dr. Johnson said that establishing such a specialty would offer protection for work in women's health care against the changing "political winds." She noted that pediatrics and geriatrics can provide the model for such a specialty. Just as research into the health of the subpopulations covered by these specialties improved the health of those populations, specializing in women's health issues could do the same for women.

Medical students who are interested in women's health issues would no longer need to "customize" their education programs, nor feel ostracized from the profession. Dr. Johnson also said that a women's health specialty ought to be established simply "because it's fair."

WHILE CONFERENCE ATTENDEES generally seemed to endorse the concept of a new specialty in women's health, there were dissenters. Michelle Harrison, M.D., assistant professor of psychiatry at the University of Pittsburgh School of Medicine, who followed Dr. Johnson to the podium, is one. (Dr. Johnson sought to minimize conflict between her and her colleague, however, noting that except on the issue of a new medical specialty, they are in complete agreement.)

Dr. Harrison agreed that women's health care is in a sorry state. She noted, for example, that today a woman needs two primary care physicians - an obstetrician/gynecologist to care for her during her reproductive years and an internist to take care of everything else. "Clearly, the split is absurd," she observed.

But maintaining that the problem is one of women's invisibility in medicine, Dr. Harrison advocated revamping the medical paradigm to effectively address women's health issues. "The current body of medicine has all the information or ways to obtain that information, and skills to address the needs of women, if the system so chooses. We need to make the system so choose."

Dr. Harrison suggested that internal medicine incorporate the menstrual cycle and reproduction into its conceptual framework, but that obstetrics and gynecology be retained for treatment of reproductive difficulties; that interdisciplinary research address gaps in the understanding of female functions; that medical students be taught to identify with patients across gender lines; that all medical specialties become "user friendly" to women; and that organized medicine, including medical schools and professional societies, actively address and rectify the "unfounded assumptions about the biological inferiority of women that have been the basis for exclusion of women from medicine and from positions of leadership and power within medicine."

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## OBITUARIES

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### Baker

Neal H. Baker, M.D., of Montgomery, died April 19, 1992, at the age of 58. Dr. Baker was a 1960 graduate of the Pritzker School of Medicine of the University of Chicago.

### \*Choca

Santiago L. Choca, M.D., a psychiatrist from Chicago, died June 17, 1992, at the age of 74. Dr. Choca was a 1943 graduate of Facultad de Medicina de la Universidad de La Habana, Havana, Cuba.

### \*Cocagne

Philip E. Cocagne, M.D., a general practitioner from Vandalia, died June 21, 1992, at the age of 75. Dr. Cocagne was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

### \*\*Cunningham

Danl R. Cunningham, M.D., an internist from Wilmette, died August 3, 1992, at the age of 91. Dr. Cunningham was a 1929 graduate of Rush Medical College, Chicago.

### \*\*Fournier

Harry J. Fournier, M.D., a surgeon from Chicago, died June 21, 1992, at the age of 86. Dr. Fournier was a 1930 graduate of the Faculty of Medicine of the Aristotelian National University of Athens, Athens, Greece.

### \*\*Friedman

Elmer A. Friedman, M.D., an otolaryngologist from Chicago, died June 24, 1992, at the age of 83. Dr. Friedman was a 1935 graduate of Rush Medical College, Chicago.

### \*\*Garcia

Benito C. Garcia, M.D., a pulmonary diseases specialist from Niles, died July 18, 1992, at the age of 79. Dr. Garcia was a 1939 graduate of the College of Medicine of the University of the Philippines, Manila, Philippines.

### \*Goldflies

Jerome Goldflies, M.D., a general practitioner from Lincolnwood, died July 8, 1992, at the age of 73. Dr. Goldflies was a 1946 graduate of Chicago Medical School.

### \*\*Gullickson

Miles J. Gullickson, M.D., a surgeon from Napa, Calif. (formerly of Rockford), died August 19, 1992, at the age of 81. Dr. Gullickson was a 1935 graduate of the University of Minnesota Medical School, Minneapolis.

### \*\*Hansen

Alton S. Hansen, M.D., a psychiatrist from Sun City West, Ariz. (formerly of Peoria), died June 22, 1992, at the age of 87. Dr. Hansen was a 1931 graduate of Rush Medical College, Chicago.

### \*Johnson

Hugh A. Johnson, M.D., a plastic surgeon from Rockford, died July 21, 1992, at the age of 73. Dr. Johnson was a 1943 graduate of Northwestern University Medical School, Chicago.

### Kallen

Irwin A. Kallen, M.D., of Chicago, died May 12, 1992, at the age of 78. Dr. Kallen was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

### \*\*Kaplan

Philip Kaplan, M.D., a surgeon from Chicago, died July 13, 1992, at the age of 86. Dr. Kaplan was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

### \*Klitenick

Edward F. Klitenick, M.D., a general practitioner from Melrose Park, died May 14, 1992, at the age of 68. Dr. Klitenick was a 1952 graduate of the University of Illinois College of Medicine, Chicago.

### \*Landa

Stuart J. Landa, M.D., a plastic surgeon from Chicago, died July 26, 1992, at the age of 66. Dr. Landa was a 1955 graduate of Medische Faculteit Rijksuniversiteit te Leiden, Leiden, Netherlands.

### \*\*Livingston

A.E. Livingston, M.D., an internist from Bloomington, died August 10, 1992, at the age of 79. Dr. Livingston was a 1938 graduate of Northwestern University Medical School, Chicago.

### \*Ludwig

Daniel C. Ludwig, M.D., a general practitioner from Wilmette, died August 29, 1992, at the age of 61. Dr. Ludwig was a 1957 graduate of Chicago Medical School.

### Mitchell

Joseph Henry Mitchell, M.D., of Chicago, died September 3, 1992, at the age of 80. Dr. Mitchell was a 1938 graduate of the Howard University College of Medicine, Washington, D.C.

### \*\*Newman

Louis B. Newman, M.D., a physical medicine and rehabilitation specialist from Chicago, died June 27, 1992, at the age of 92. Dr. Newman was a 1933 graduate of Rush Medical College, Chicago.

### \*O'Connor

Vincent J. O'Connor Jr., M.D., a urologist from Glenview, died August 27, 1992, at the age of 65. Dr. O'Connor was a 1953 graduate of Northwestern University Medical School, Chicago.

### \*Platzbecker

David A. Platzbecker, M.D., a family physician from Atwood, died July 10, 1992, at the age of 53. Dr. Platzbecker was 1964 graduate of the University of Illinois College of Medicine, Chicago.

### \*Pitaro

Nathan A. Pitaro, M.D., a general practitioner from Burr Ridge, died June 24, 1992, at the age of 64. Dr. Pitaro was a 1953 graduate of Facolta di Medicina e Chirurgia dell'Universita di Bologna, Bologna, Italy.

### \*Schendl

Raymond F. Schendl, M.D., an anesthesiologist from Peoria, died June 22,

1992, at the age of 59. Dr. Schendl was a 1959 graduate of Loyola University Stritch School of Medicine, Maywood.

### \*Shaffer

Aaron B. Shaffer, M.D., a cardiovascular diseases specialist from Skokie, died July 29, 1992, at the age of 65. Dr. Shaffer was a 1950 graduate of McGill University Faculty of Medicine, Toronto, Ontario, Canada.

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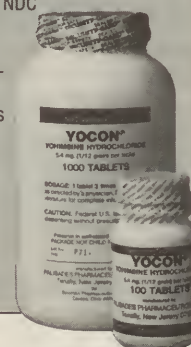
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### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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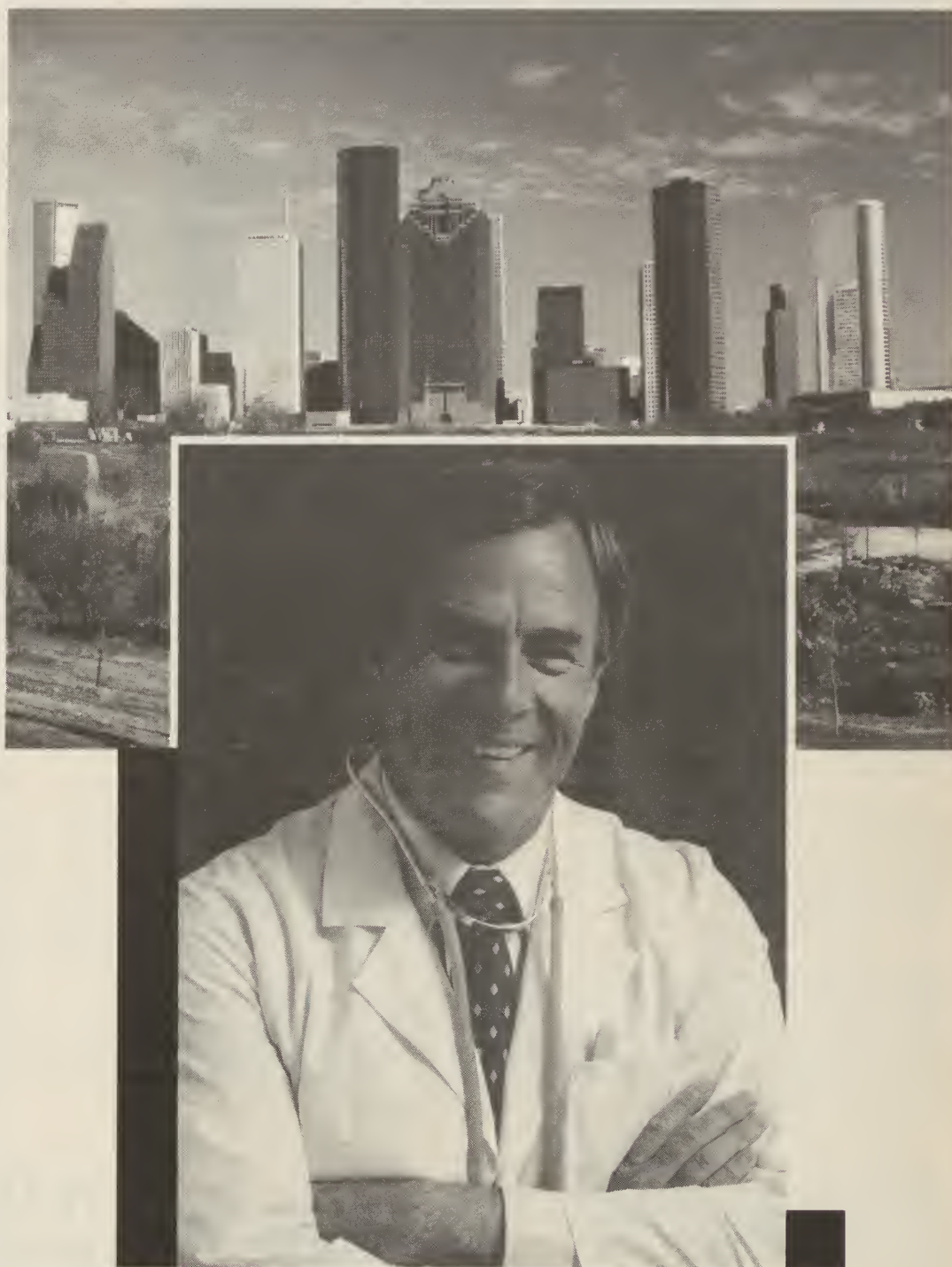
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## FDA official announces revisions to CME enforcement policy

(Continued from page 1)

ence's opening session. Indeed, that session's moderator, Daniel J. Ostergaard, M.D., of the American Academy of Family Physicians, successfully undertook to pin Taylor down on the matter.

"I don't need to be coy about [the document's] existence," Taylor acknowledged. "I think we'll be able to have a formal publication of the document [in the *Federal Register*] fairly soon."

**THE SOON-TO-BE-RELEASED** document is actually a third version of a concept paper issued in October 1991, right after last year's conference, which sent shock waves through the CME community and precipitated intense negotiation with the FDA. "We've listened, and we've learned," said Taylor. "I believe we have a better-articulated policy than we did last year."

Taylor defended the agency's statutory obligation to regulate foods, drugs and medical devices for safety and effectiveness, and to ensure that promotional materials are "truthful, not misleading and fairly balanced."

But saying the FDA was "clarifying an already existing policy," he added that

the FDA would not regulate "company-supported CME that is independent of promotional influences and not promotional in content." In addition, in what many conferees considered a major breakthrough, Taylor said the FDA would work closely with private accrediting organizations in monitoring compliance and would "to the extent possible defer to these organizations in their oversight of accredited providers."

Taylor noted the forthcoming policy statement incorporates seven significant revisions to the controversial October 1991 concept paper that describe "safe harbors" [see box below] in CME program planning. All had been areas of contention between the government and the CME community.

Several participants hailed the new atmosphere of cooperation not only between the CME community and the government, but among the members of the community itself.

"The results of our efforts will strengthen ACCME's accreditation process, create a positive environment for continued support of CME by the industry, and provide a level of public

accountability and credibility necessary for the 1990s and beyond," said ACCME's Dr. Jay.

"The interest of patient care and physician education [means] the impasse that we've had with the FDA will be broken," said Gerald Mossinghoff, president of the Pharmaceutical Manufacturers Association. Mossinghoff said the PMA Board of Directors had also adopted the ACCME standards as industry policy.

Noting that the "process of change really began with the profession," AMA General Counsel Kirk B. Johnson said, "The process over the last year or so with the profession, the FDA and the academic institutions has been a remarkable example of negotiation at work." He also noted that "this kind of negotiation, this almost partnership" could serve as a model for "tough choices" among limited resources in general health care reform.

**SOME DISSENTERS MAINTAINED** that corporate funding of CME programs is decreasing in the wake of anticipated increased government regulation and

that FDA intrusion into the information marketplace constitutes a violation of First Amendment rights – the industry's and the profession's. And although most conferees were encouraged by the improved atmosphere, contrasted with the last two conferences, participants expressed several concerns. These included anxiety regarding the implementation and monitoring of compliance with both the ACCME standards and the forthcoming FDA guidelines, especially in the area of financial disclosure; a need to clarify ambiguous terms in the standards; and the need for a massive campaign to educate the entire CME community about the changes ahead. ■

## FDA official outlines seven CME 'safe harbors'

During remarks at a recent national conference of continuing medical education, U.S. Food and Drug Administration Deputy Commissioner for Policy Michael R. Taylor outlined seven practices that will constitute "safe harbors" in commercially supported CME. These practices will be announced officially when the FDA's guidelines for industry-supported CME are published for comment in the *Federal Register*.

- Companies will be permitted to recommend the names of possible presenters for CME programs but cannot require their use as a condition for providing commercial support.
- For certain products, discussion of single treatments may be appropriate when there are no alternative treatments; if alternatives exist there should be objective discussion.
- There will not be a blanket prohibition of repeat performances; such programs will likely get more scrutiny.
- Companies may offer technical support, such as the preparation of slides, for presenters who request such assistance. Such materials must be objective in content and approved by the sponsoring organization.
- Presenters and moderators who have a financial relationship with the sponsoring company may participate as long as the relationship is disclosed.
- Companies may discuss the proposed program topic with the presenter before deciding whether to sponsor the event.
- The FDA will no longer suggest that companies offering commercial support of CME programs monitor those programs to guard against content that does not conform to agency policy. ■

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**ISMS PRESIDENT**

Arvind K. Goyal, M.D. (right), joined Kane County Medical Society President Michael I. Rosenberg, M.D., at a lunch forum Oct. 21 at Delnor Community Hospital in Geneva. Community leaders and medical society board members attended the discussion, "Health Care Issues of Community Concern."

**After you vote, they will vote***(Continued from page 1)*

being a "part-time" legislator because of his medical practice. She was supported by the Illinois Trial Lawyers Association, Illinois Public Action and many labor unions.

Dr. Deets worked hard in his district, both as an incumbent legislator and in his campaign, walking precincts with his family. His campaign strategy stressed his record and the issues of jobs, education, property tax relief and, of course, health care. Dr. Deets is a 32-year Dixon resident, and has served on the Chamber of Commerce and the Industrial Development Commission. His opponent's strategy was primarily one of attacking him.

Physicians were involved in many of the elections involving 177 members of the Illinois General Assembly, 20 mem-

bers of Congress and one U.S. senator. Physicians and their families participated in voter registration drives; wrote candidate support letters; gave money to IMPAC, the ISMS Political Action Committee, and directly to candidates; and worked in campaigns.

The legislators who were elected will probably be called upon to vote for or against legislation on a single-payer, government-run health insurance program; laws that regulate medical malpractice lawsuits; regulations on how physicians practice medicine; rules that govern allied health professionals; and tax increases to pay for it all.

Physicians and their families now must work with those candidates who have been elected. We can't afford to sit back and allow these important decisions and votes to be made without trying to educate these legislators about medical issues and what's important to our patients. ISMS will establish contact with newly elected legislators and will reinforce support with returning legislators. We need your help. If the candidate you supported won, offer congratulations. Make personal contact to reinforce your interest in the person – and the issues.

*Regardless of who won,  
make it your business to  
know something about  
the people representing  
you now.*

Regardless of who won, make it your business to know something about the people representing you now in the state and national legislatures. You may need to contact them next spring about important votes they will be casting on issues that affect you and your patients. If you don't know who won in your legislative district, call ISMS and ask for the Governmental Affairs Division.

At the time this is being written, we don't know the outcome of Dr. Deets' race. But it is a classic one, showing how one physician is trying to serve the people in his district and his patients. We fervently hope he wins. Somehow, we don't think it's too much to have one physician in the legislature, when there are so many lawyers. Regardless of the outcome, we salute Dr. Deets, a long-time ISMS member, and his family for their sacrifice, hard work and public service. ■

**Children's immunization***(Continued from page 1)*

To meet state recommendations, each child must receive four doses of DPT (diphtheria, pertussis/whooping cough and tetanus), three doses of OPV (oral polio vaccine) and one dose of MMR (measles, mumps and rubella).

As part of the Illinois effort, more than \$13 million in federal and state money will be spent to purchase 1.4 million doses of vaccine in the 1993 state fiscal year. ■

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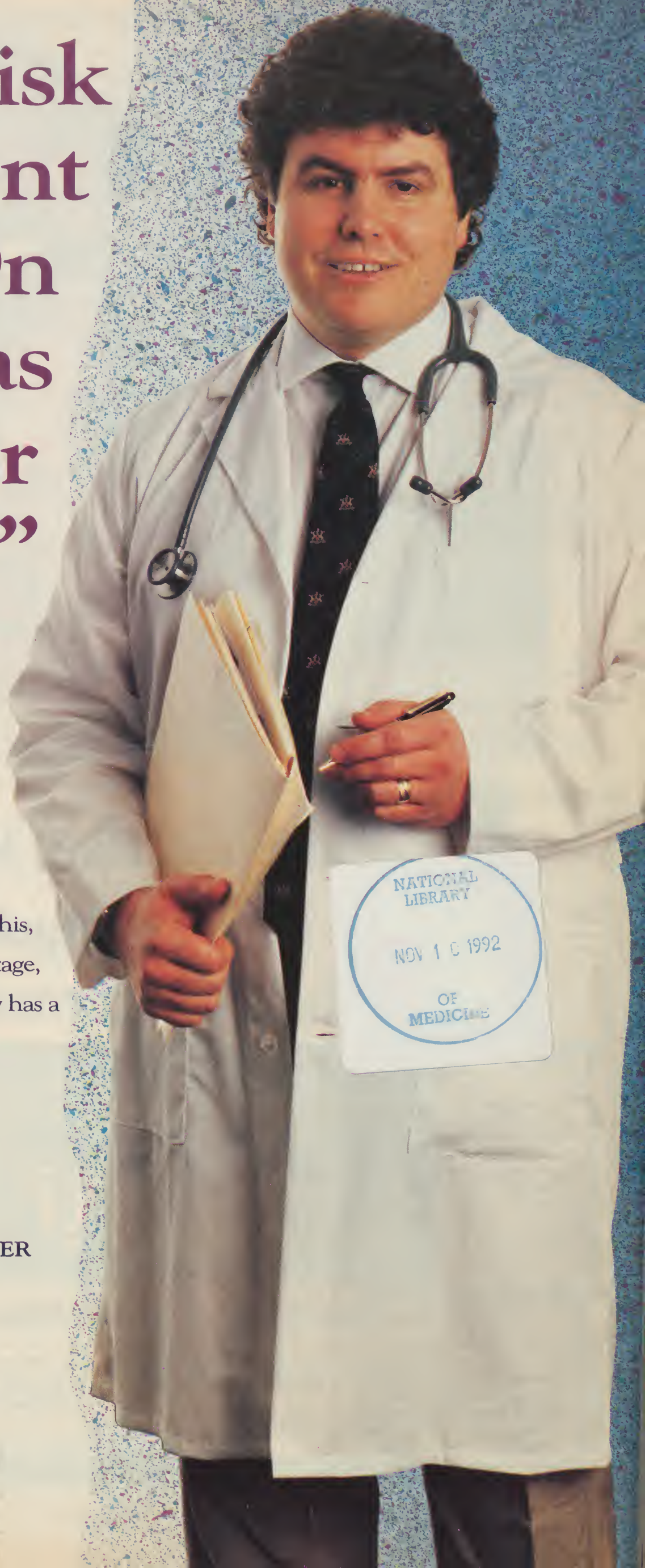
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## Results of key races

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# Illinois Medicine

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Are they  
smoking in  
Skydome?

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Gov. Edgar

## Governor appoints health care task force

**TASK FORCE:** Illinois Gov. Jim Edgar begins addressing the state's health care crisis by naming a health care reform task force.

By Tamara Strom

[ SPRINGFIELD ] Gov. Jim Edgar moved toward lowering health care costs and improving access to care for Illinois' poor and uninsured residents Nov. 5 by announcing the formation of a 36-member health care task force. Among those on the task force to provide medicine's input is Alexander R. Lerner, Illinois State Medical Society executive vice president. Joining Lerner on the blue-ribbon

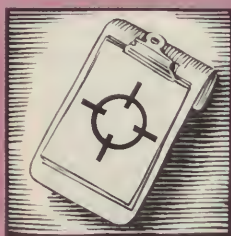
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## INSIDE

### Survey says

Illinois residents favor insurance industry reform

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### Case in Point explores hysterectomies

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supervisor wins November

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# Power shifts in Illinois General Assembly

**ELECTION:** Redistricting put Republicans in charge of the state Senate and helped them make gains in the House. By Kevin O'Brien

[ SPRINGFIELD ] Redistricting and a coin toss did the trick.

Illinois Republicans vying for control of the state Senate after 18 years of Democratic dominance picked up four seats in the Nov. 3 election, capturing 32 of the 59 seats. The 32-27

Republican majority all but ensures that DuPage County Sen. James "Pate" Philip will succeed retiring Senate President Philip Rock of Oak Park as head of the upper chamber.

The GOP Senate victory in an otherwise Democratic year is

attributed to Republicans' winning the coin toss that gave them a one-vote majority on the redistricting commission that drew the new legislative maps. And, although Democrats held on to a decisive 67-51 majority (Continued on page 18)

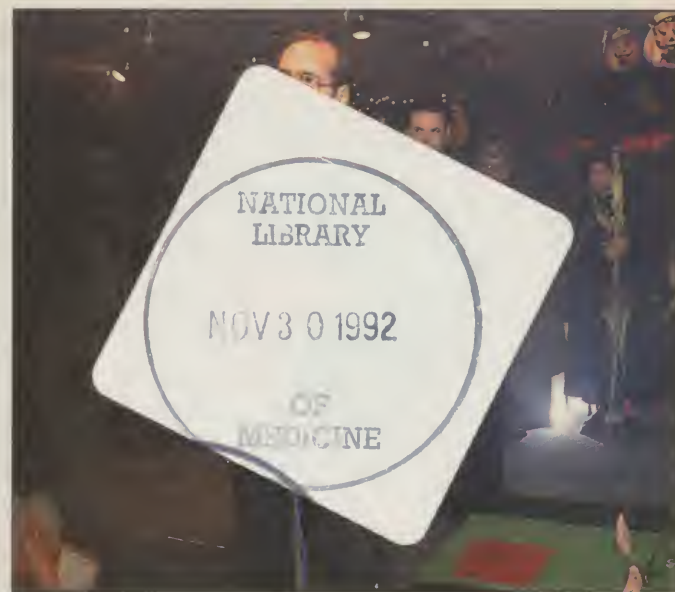
## President vetoes Medicare changes

**VETO:** Changes in the Medicare system sought by the AMA fell victim to President Bush's veto pen. By Tamara Strom

[ WASHINGTON, D.C. ] By keeping his promise to veto the tax and urban aid bill sent by Congress, President Bush Nov. 4 also rejected American Medical Association-backed Medicare amendments tagged to the measure.

"The President vetoed the bill for reasons unrelated to these

(Continued on page 22)



M. CANDEE STUDIOS

**IDPH DIRECTOR JOHN R. Lumpkin, M.D.,** unveils Illinois' new teen AIDS education campaign, which enlists Dracula as its spokesperson.

"An AIDS education campaign featuring Dracula as the spokesperson seems oddly appropriate," said Dr. Lumpkin at an Oct. 30 press conference in Chicago. "There are many creatures of myth and folklore that have been haunting our attempts to carry out AIDS education."

Dracula's message is "Stop living in the dark - get the facts about AIDS." The Dracula campaign includes TV and radio public service announcements, brochures, posters, transit cards and billboards.

## TACKLING THE ISSUES

## ACCESS COMMITTEE ADDRESSES RURAL HEALTH NEEDS

The Illinois State Medical Society's Committee on Health Care Access hasn't forgotten its roots.

Originally convened as the Rural Health Committee, the group's focus was broadened in 1991. Noting that access to health care is an issue in the inner city as well as in the rural areas outside Illinois' cities' limits, the ISMS Board of Trustees expanded the committee's scope and changed its name.

The problems of Illinois citizens in obtaining

health care in rural areas have not been forgotten, however. The committee just released its new action-oriented, problem-solving publication "Rural Health: Reaping the Benefits of Community Action," a guide for physicians and community leaders.

The publication is actually two booklets.

One, focuses on

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## Survey says Illinois residents favor insurance industry reform

**REFORM:** A survey commissioned by Blue Cross and Blue Shield of Illinois shows most Illinois residents favor more managed care competition to reform the health care system. By Kevin O'Brien

[ CHICAGO ] Fifty-nine percent of the respondents to a survey commissioned by Blue Cross and Blue Shield of Illinois said they favored a "managed competition" plan. About two-thirds favored a "pay or play" system (37 percent) or a "market based" plan (33 percent). Only 15 percent favored a single-payer, government-run health care system.

Respondents were asked to react to three specific components of four health care reform proposals. These components consisted of specific suggestions for how each proposal would make health care available to everyone; how each proposal would fund the suggested reform system; and how each

proposal would control costs. (The percentages add up to more than 100 percent because they represent the choices of respondents who favor *all three* of the suggested components in each of the four proposals, and some people prefer more than one alternative.)

Noting that President Bush and President-elect Bill Clinton have included managed competition as a component of their respective health care reform plans, Blue Cross officials used the results to buffer the not-for-profit company's advocacy of more managed care networks as the most effective means of overhauling the system.

"We have always believed 'managed competition' among high-quality health

care networks could solve our health care crisis," said Theodore E. Desch, Blue Cross senior vice president. "This survey shows there is strong public support for our type of reform plan."

Results of the statewide telephone survey, conducted Aug. 4-5 by the Rabin Research Co. of Chicago, were released Oct. 27. Respondents were 406 residents reflecting a cross section of the state's population in terms of gender; age (21 to 39, 40 to 64, 65 and over); and location (Chicago, Chicago suburbs and outside the metropolitan area).

The four health care reform proposals that respondents were asked to consider included a single-payer, govern-

ment-run system, in which physician and hospital fees are set by the government; a "pay or play" system, in which companies that do not provide health insurance for their employees pay a health care tax; a "market based" plan, in which the government issues vouchers to help low- and middle-income people purchase insurance; and a "managed competition" plan, in which the insurance industry is reformed to prohibit discrimination against people with pre-existing conditions while making insurance more affordable.

The survey noted that "Illinois residents do not feel there is a clear cut solution to health care problems.

(Continued on page 18)

## Illinois sets smoke-free sticker precedent

[ CHICAGO ] The success of a "smoke free" window sticker campaign launched last year by the Illinois Division of the American Cancer Society has prompted the national American Cancer Society to reproduce two new stickers for national distribution.

The first sticker, which states "Breathe Easy ... This Establishment is Smoke-free," is intended to reward businesses and restaurants that ban smoking, and to advise the public that establishments are smoke free. The second sticker, "Breathe Easy ... This Vehicle is Smoke-free," was created by the Illinois Division and distributed to the public following the success of the first, a cancer society spokesperson said.

The Illinois Division received phenomenal response from both stickers, the spokesperson said. As part of its anti-tobacco initiative beginning every November with the Great American Smokeout and continuing throughout the year, the society presents stickers and certificates to businesses that ban smoking on their premises.

In Chicago, the Illinois Division distributed 3,000 vehicle stickers to the Yellow Cab Co. for display in taxis across the city. ■

## Mammography ad campaign targets Hispanics

[ CHICAGO ] The American Cancer Society, Illinois Division, is sponsoring an advertising campaign urging Hispanic women to have mammograms. Introduced citywide in May, the campaign, "Tomese el Tiempo" or "Take the Time," is the cancer society's first Spanish-language public awareness program, and has received widespread television and radio airtime in the Hispanic media.

"We determined that for a mammography public awareness campaign to effectively reach women in Chicago's Hispanic community, that campaign would have to be both culturally relevant and in Spanish," said Illinois Divi-

sion Chairman Stan Tannenbaum.

In Hispanic culture, women traditionally place the welfare of their children and husbands before their own, and this priority extends to health care, Tannenbaum said. "Mothers who would not hesitate to devote time and money to taking their children to visit a doctor's office or clinic would feel hard-pressed to consider expensive health care for themselves."

The campaign, which was designed by leading Chicago Hispanic advertising agency San Jose and Associates on a largely pro bono basis, focuses on His-

panic women's dedication to family above all else, Tannenbaum said. In addition, the society asked U.S. Surgeon General Antonia Novello, M.D., to be the television spokesperson, since "it was essential that the American Cancer Society's message be delivered by someone who could command enough respect to motivate Hispanic women to consider this screening test, despite their feelings of modesty."

The ads, which have reached an audience of approximately 612,000, provide information about mammography and encourage contacting the society for a

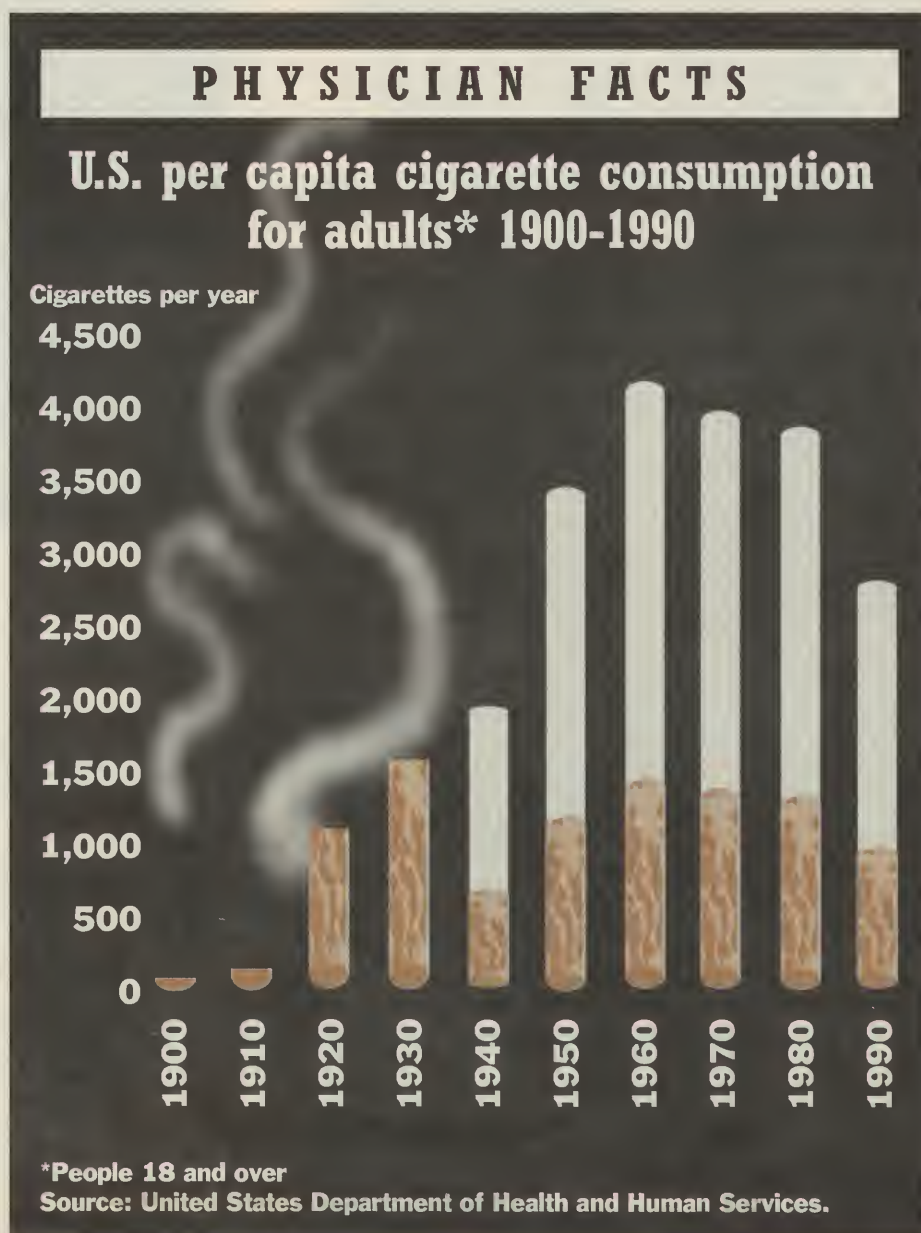
list of accredited mammography facilities. Also offered is an American Cancer Society mammography brochure in Spanish describing the society's mammography demonstration project in Humboldt Park and Little Village. The society hopes increased public awareness will result from the ad campaign in 1993, Tannenbaum said. The society next plans to launch anti-tobacco and nutrition campaigns aimed at Hispanics. ■

## Study gives Illinois D+ for children's health

[ CHICAGO ] Illinois deserves only a D+ for providing adequate health care to the state's 3.3 million children, according to a new study. Released Oct. 20 by the advocacy group Voices for Illinois Children, the *Illinois Kids Count* study showed 14.3 percent of children statewide lack health insurance. The study also showed increasing numbers of Illinois children are born with health problems, such as low birth weight.

"This is a lousy report card," said Nancy Stevenson, chief executive officer of Voices for Illinois Children. "These grades are unacceptable. Imagine what a parent would say if his or her child brought home a report card with these grades. ... Illinois must work harder."

Specifically, the study highlights a 5-percent increase in low-birth-weight babies born in Illinois during the past decade, ranking Illinois 39th among the 50 states. Fifty-four Illinois counties showed increases in the rate of low-



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birth-weight babies, while 24 counties experienced decreases, the study said.

Although Illinois' infant mortality rate dropped 27 percent in the 1980s, the state's current rate of 10.69 per 100,000 live births ranks only 46th in the nation, the study reveals. The decrease in infant mortality over the past 10 years is in part attributed to earlier prenatal care. But the study stresses that prenatal and obstetrical care is increasingly difficult to obtain in many parts of the state.

"In rural counties, especially in the southern and eastern parts of the state, pregnant women are unable to find doctors willing to provide prenatal care and deliver babies because of the high cost of malpractice insurance," the study report says. "Malpractice rates are much lower in neighboring Indiana, and many doctors have left to practice there. Many southern [Illinois] doctors also leave for Missouri because Missouri has a lower number of Medicaid recipients near the Illinois border."

The study terms the number of uninsured Illinois children "intolerable" and calls for heightened state efforts to provide care to the 350,000 children without health insurance. While acknowledging federal cooperation is necessary to solve the country's "health care scandal," the study recommends that Illinois provide prenatal care and other basic health services to low-income pregnant women and children who lack insurance. The study also calls for more preventive health care.

"We are definitely not pleased with the scores, and we recognize we have some work to do," said a spokesperson for Gov. Jim Edgar about the study results. "But since the governor took office, his administration has made kids its No. 1 priority and has tried to develop programs and services that aid children. We will continue to put resources into programs that benefit children and families."

The state has already begun addressing health access barriers with the implementation of the Department of Public Aid's \$19.1 million Healthy Moms/Healthy Kids initiative, the governor's office said. "This program is one of the ways the state is working to increase access to health care for pregnant women and children and improve the quality of health care for those two populations," the spokesperson told *Illinois Medicine*. In addition, the governor hopes the newly named health care reform task force will offer recommendations to improve health care access in Illinois. (See related story, page 1). ■

## ISMS offers information on practice parameters

The Illinois State Medical Society is offering free copies of "Understanding Practice Parameters" – a paper on medical algorithms for physicians – to ISMS members. Included is information about the effect of practice parameters on quality assurance, utilization review, third-party payments and professional liability. To order a copy, fill out and return the card between pages 20 and 21. ■

## Physicians must complete more CLIA forms

[ CHICAGO ] Hold on to your dipstick: The federal government is requiring physicians who perform office laboratory tests to fill out yet more forms. Physicians already in compliance with the Clinical Laboratory Improvement Amendments of 1988 completed the HCFA-109 form to receive their registration certificates. Now those same doctors must fill out and return the new HCFA-114 and HCFA-116 forms the U.S. Health Care Finance Administration mailed to physicians Nov. 3. The surveys must be returned within 30 days after the doctor receives them.

The new forms collect specific information about doctors' office laboratories, providing a baseline survey that lab investigators can use to inspect those office labs subject to

inspection under CLIA. HCFA also will use the forms to assess fees and issue registration certificates.

Physicians who have not yet registered with HCFA (the deadline is Dec. 1) need forms 114 and 116 to bring their labs into compliance, so they can operate them legally. Under CLIA, even physicians performing only simple lab tests must register. The forms come with instructions, but if physicians have additional questions they may contact HCFA's CLIA program at (410) 290-5850. Although most physicians should receive the questionnaires in the mail, doctors who do not receive them may call HCFA or the Illinois State Medical Society's medical services department at (312) 782-1654 or (800) 782-ISMS. ■

# Blue Cross Blue Shield



## REPORT FOR Illinois Physicians

### MINIMUM CRITERIA FOR ANESTHESIA SERVICES

Physicians who perform direct or concurrent anesthesia services are reimbursed on a reasonable charge basis provided that the following conditions are met:

For each patient, the physician --

- performs a pre-anesthetic examination and evaluation;
- prescribes the anesthesia plan;
- personally participates in the most demanding procedures in the anesthesia plan, including induction and emergencies;
- ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual;
- monitors the course of anesthesia administration at frequent intervals;
- remains physically present and available for immediate diagnosis and treatment of emergencies; and
- provides indicated post-anesthesia care.

None of these "bundled" services may be billed separately by a physician. This rule applies even though the surgical anesthesia was personally performed or medically directed by a physician or if the surgical anesthesia was performed by a CRNA without medical direction.

In addition, the physician either performs the procedure directly, without the assistance of a CRNA, OR directs no more than four anesthesia procedures concurrently. He or she cannot perform any other services while directing the concurrent procedures.

### ANESTHESIOLOGISTS MEDICALLY DIRECTING ONE PROCEDURE

Concurrent medical direction refers to an anesthesiologist directing concurrent anesthesia procedures (two, three, or four concurrent procedures.) When an anesthesiologist and a CRNA are both involved in a SINGLE anesthesia service, the service is considered personally performed by the anesthesiologist. No separate payment is recognized for the CRNA's service unless documentation is submitted indicating that it was medically necessary for both the anesthesiologist and the CRNA to be involved.

If an anesthesiologist medically directs a CRNA during one procedure, the anesthesiologist should inform the CRNA, prior to the service, that the CRNA's charges will be denied by the Medicare program as not medically necessary - the patient cannot be billed by the CRNA. If it was medically necessary for both the anesthesiologist and CRNA to be present, BOTH entities should document this information on their billings.

### PAYMENT FOR POST OPERATIVE PAIN MANAGEMENT

The surgeon should manage postoperative pain except under special circumstances. If a surgeon's patients routinely receive pain management services from an anesthesiologist, the global fee for the surgeon will be reduced.

For pain management by continuous epidural:

- a. Payment to the anesthesiologist for 62279 is allowed once, on the first day of service. This code includes the catheter and injection of the anesthetic substance.
- b. Payment to the anesthesiologist is allowed for 01996 for daily management of the epidural drug administration after the day on which the catheter was introduced. Both 01996 and 62279 are not payable on the same day.

HCFA has instructed the carrier not recognize time units for anesthesia codes 01995 and 01996 in 1992. Services for these two codes will now be paid by multiplying the RVU for the code by the anesthesia conversion factor. (One time unit will no longer be added to the RVU.) This change may result in reduced reimbursement for these procedures.

Payment for physician services related to patient controlled analgesia (PCA) is included in the global fee paid to the surgeon. Other services of the nursing staff in administering medications are routine hospital expenses included in the DRG for the hospital stay.

(11/20/92)



# Results of key U.S. congressional and Illinois General

✓ indicates winner  
\* indicates incumbent

## U.S. Senate

Richard S. Williamson (R)  
✓ Carol Moseley Braun (D)

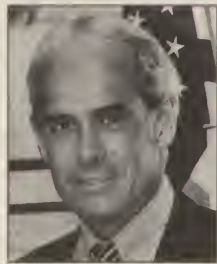
## U.S. House of Representatives

2nd District  
Ron Blackstone (R)  
✓ Mel Reynolds (D)



Philip M. Crane

8th District  
✓ Philip M. Crane\* (R)  
Sheila Smith (D)



John E. Porter

10th District  
✓ John E. Porter\* (R)  
Michael J. Kennedy (D)



J. Dennis Hastert

14th District  
✓ J. Dennis Hastert\* (R)  
Jonathan Abram Reich (D)

9th District  
Herbert Sohn, M.D. (R)  
✓ Sidney R. Yates\* (D)

11th District  
Robert T. Herbolsheimer (R)  
✓ George E. Sangmeister\* (D)

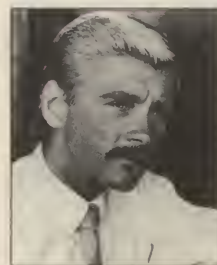
15th District  
✓ Thomas W. Ewing\* (R)  
Charles D. Mattis (D)

16th District  
✓ Donald Manzullo (R)  
John W. Cox Jr.\* (D)

## Illinois Senate

7th District  
✓ Walter W. Dudycz\* (R)  
James M. McGing (D)

18th District  
✓ Patrick J. O'Malley (R)  
John J. McNamara (D)



Robert M. Raica

24th District  
✓ Robert M. Raica\* (R)  
Anita M. Cummings (D)

29th District  
Roger A. Keats\* (R)  
✓ Grace Mary Stern (D)

34th District  
✓ Dave Syverson (R)  
Joyce Holmberg\* (D)

35th District  
✓ J. Bradley Burzynski (R)  
John M. Nelson (D)

37th District  
✓ Todd Sieben (R)  
Eric Gubelman (D)



Dan Cronin

39th District  
✓ Dan Cronin (R)  
Ted E. Leverenz\* (D)

43rd District  
Charles "Chuck" Pangle (R)  
✓ Thomas A. Dunn\* (D)



Karen Hasara

50th District  
✓ Karen Hasara (R)  
Douglas Kane (D)

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# Assembly races

## 55th District

✓ Frank C. Watson\* (R)  
Craig Virgin (D)



Ralph Dunn

## 58th District

✓ Ralph Dunn\* (R)  
Kenneth V. Buzbee (D)



Dan Rutherford

## 87th District

✓ Dan Rutherford (R)  
Chuck Rolinski (D)

## 95th District

DeWayne Bond (R)  
✓ Bill Edley\* (D)



Tom Ryder

## 97th District

✓ Tom Ryder\* (R)  
Henry G. Jackson Jr. (D)

## 102nd District

✓ N. Duane Noland\* (R)  
Doug Wolfe (D)

## 103rd District

Gregory D. Cozad (R)  
✓ Laurel Lunt Prussing (D)

## 104th District

✓ Timothy V. "Tim" Johnson\* (R)  
Helen F. Satterthwaite\* (D)

## 106th District

✓ Michael "Mike" Weaver\* (R)  
Carolyn Brown Hodge (D)



Ron Stephens

## 110th District

✓ Ron Stephens (R)  
Robert Daiber (D)

## Illinois House of Representatives

### 35th District

Jane M. Barnes\* (R)  
✓ Terry A. Steczo\* (D)

### 36th District

✓ Maureen Murphy (R)  
Andrew J. McGann\* (D)

### 37th District

Carl James Vandenberg (R)  
✓ John R. Sheehy (D)

### 47th District

James R. Donoval (R)  
✓ David B. McAfee\* (D)

### 58th District

Jim Henderson (R)  
✓ Jeff Schoenberg\* (D)



Virginia Fiester Frederick

## 59th District

✓ Virginia Fiester Frederick\* (R)  
John S. Matijevich\* (D)

### 60th District

Charles A. Cardella (R)  
✓ Lauren Beth Gash (D)

### 69th District

David Winters (R)  
✓ Michael V. Rotello\* (D)

### 73rd District

David K. Deets, M.D.\* (R)  
✓ Pennie L. von Bergen Wessels (D)

### 74th District

✓ I. Ronald Lawfer (R)  
Richard T. "Dick" Mulcahey\* (D)



Angelo "Skip" Saviano

## 77th District

✓ Angelo "Skip" Saviano (R)  
Geoffrey S. Obrzut\* (D)

### 80th District

Robert P. Regan\* (R)  
✓ John A. Ostenburg (D)



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# Illinois Medicine

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## EDITORIAL

### Up in smoke

When Christopher Columbus returned from his first voyage to the New World, he was greeted with that ancient and familiar question from his nearest and dearest: "What did you bring me?"

The things he brought changed history. He brought potatoes. He brought cocoa. And he brought tobacco.

Maybe we should think of the last item as the American Indian's revenge.

When *Illinois Medicine* went out to interview Real People for our "man in the street" feature, our roving reporter looked for people who were smoking. (See Snapshot, page 13.)

Amazingly, none of those interviewed would defend their right to smoke – more than one, in fact, admitted how unhealthy the habit is. And none would allow us to photograph them smoking. The day of the militant smoker is over.

Maybe all the new laws and regulations, the personal and peer pressure are beginning to work. Maybe the dirty looks and pointed remarks that non-smokers make to and about people who are smoking are having an impact.

The next step is for physicians to get aggressive in confronting their patients who smoke. We need to talk to these people – and even more important, we need to listen to them.

Changing the laws about where people

can and cannot smoke is only one part of the problem. Breaking the habit is what we need to focus on.

What is available to help your patients who smoke? New nicotine systems like transdermal patches, nicotine gums, behavior modification groups like Smoke Enders – all of these offer help to the patient who wants to quit.

The challenge comes in persuading someone to want to quit. That's where you come in, doctor.

Querying patients about their tobacco habits should be only the first step. Selling the hard facts about the dangers of smoking is what must come next. Lay it on the line with them. You can't afford to figure that it's not your business. It is your business – just as the heart attack, the stroke, the lung cancer that a smoker and his/her family face will be your business. Sooner or later a smoker – or a smoker's estate – will be successful in suing a tobacco company. The next step will be to sue the physician who didn't do enough to warn the smoker away from this terminal habit.

You wouldn't tolerate your patients' playing Russian roulette in front of their children, in their homes, their cars, their offices, in closed and open stadia across the state.

The time is here to say we won't tolerate smoking, either.

## PRESIDENT'S LETTER

### Silence is not always golden – let's talk about the hospital Medicaid assessment program

By Arvind K. Goyal, M.D.



*"As available dollars shrink, the impact of overpromised but underfunded Medicare and Medicaid programs has intensified."*

One stormy night, Frank Lloyd Wright, the renowned architect, was awakened by a phone call from a client who had just moved into his new house. "There's a leak in the roof and the living room is flooded," cried the man. "What shall I do?" Wright counseled, "For the time being, rise above it."

The storms have been hitting hard and often at our shorelines lately and also our public health care programs. As the available dollars shrink, the impact of overpromised but underfunded Medicare and Medicaid programs has intensified in recent years while the numbers and medical needs of those served, and mandates and wish lists from Washington multiply. Many caring and dedicated physicians in Illinois continue to care for Medicaid patients for no pay, low pay and slow pay – on an average 30 cents per dollar billed, 60-plus days after service. Hospitals, which collect 70 cents per their billed dollar, nursing homes and other providers have had to contend with similar pressures. Yet everybody with privileges of caring for people has remained committed to insuring care to all those in need.

The state budget shortfall in spring of 1991 generated a lot of concern, debate and shots at possible solutions. Following the lead of some other states, the Illinois Hospital Association proposed an assessment program that would raise money by "assessing" each institution to attract federal matching funds with guaranteed return of at least as much as they would "give." An assessment would therefore quickly double with federal matching, and the original amount could then be returned to the contributing institution, leaving the federal contribution intact to pay hospital and long-term care bills for Medicaid recipients. Institutional providers – hospitals and nursing homes – bought into this "free program." Fearing an eventual reaction by the federal government, your state medical society served your interests well by requesting exclusion of physicians from this program. No pain, no gain and no shame!

The feds got suspicious. Concerned that they couldn't control the states' hands in their pockets, the federal budget makers labeled it as "a scam." Congressional action followed. The plug got pulled. New rules were laid down that required significant change in "business as usual." They said only "Robin Hood" programs would be acceptable. Each institution would have to place its contribution at risk. Some redistribution of wealth would have to take place. Requests to extend the status quo beyond Oct. 1, 1992,

were rejected.

Our concerned governor looked at all the painful options that were left. Additional Medicaid money was badly needed to maintain viability of those institutions whose life depended on it. Or their reimbursement rate had to be cut by 30 percent. The only way to keep the train running, it seemed, was to fuel it with additional federal matching funds to the tune of \$700 million. But those would not come unless the state raised \$700 million from the institutions themselves – just like last year, except now with no guaranteed return. Some hospitals in the state, those that treated fewer poor patients yet managed to make millions, would lose the most. Others, which treated many poor patients, would get more. Anybody in the governor's shoes probably couldn't have reached a better conclusion.

The hospital association responded by publicly calling for a state income tax increase instead, something that taxpayers or lawmakers couldn't afford. Some institutions formed a lobbying group of their own. Others tried unsuccessfully to amend the proposal to tax physicians, as unfair as it sounded, to pay the "poor" hospitals. Eventually, the legislature approved and the governor signed a bill that would, for the next year, assess the hospitals 2.5 percent of their 1991 net revenues, \$6.30 per day per occupied long-term care bed, and 13 percent of residential revenue from facilities for the developmentally disabled. And everybody agreed to continue to explore better alternatives.

The hospital community was divided on this issue. Those who lost money, in some cases up to \$3 million of their \$16 million annual profit, responded by raising charges for all patients. Those hospitals who gained under the legislated assessment program, of course, supported continuance of the program.

And now comes a report from a task force of the Illinois Hospital Association that recommends taxing physicians and health insurance carriers in the state to fund the Medicaid payments to "poor" hospitals. And with that, the profitable "not-for-profit" hospitals would reduce their 2.5-percent assessment to 1 percent. They would propose taxing everybody and their brother around them and do what it takes to protect their gains.

Everybody agrees that the tax on hospitals is unfortunate. Nobody thus far has come up with a better alternative. This may be the time to ask your hospital administrator to rise above it all, and stay there!





"Yes, this is the nonsmoking section. But that's just for diners."

## GUEST EDITORIAL

## Why Washington will not solve our health crisis

**M**y son David and I just returned from a vacation in Washington, D.C. We visited the usual sites, and at the Capitol building, I had true insight into how Congress thinks and acts.

We had gallery passes to both the Senate and the House of Representatives. When we arrived at the opening of the Senate, I thought my watch was broken. Although the session was to begin at 10:30, only a few senators were present. They confirmed that morning business should end at 11 a.m., but agreed to end it at 12:30 p.m. I noticed that Sen. Robert Kerrey was presiding. The U.S. Constitution gives the vice president of the United States only one official duty: to preside over the Senate. Yet J. Danforth Quayle was too busy to perform his elected job.

As I waited, seeing no significant action or discussion, I thought about how different medicine is. I remembered emergency department shifts starting at 6 a.m., rounds starting at 6:30 a.m., operation room incisions being made at 8 a.m., and other early morning activities. I had great difficulty believing that the senators were truly busier than most of my medical colleagues.

We left the Senate gallery and went to the House of Representatives chambers. Despite the facts that there are more than 400 elected members and it was noon, fewer than 10 of our legislative leaders were present. A congressman proposed that they adjourn for the day! I sat there wondering how I could get a job like that.

We returned to the Senate and heard various senators talk and talk. Finally Sen. Robert Dole got the floor. He was concerned about a pending midnight nationwide railroad strike

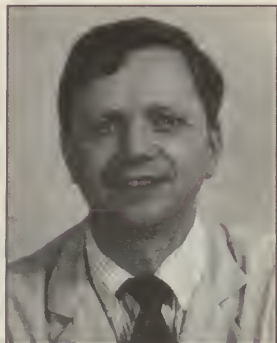
by Amtrak and Conrail, and presented an amendment to a previous bill. The language was very benign: "It is the sense of the Senate that Congress needs to act immediately to forestall a possible railroad strike to occur at midnight, tonight, since the economic ramifications of such a strike are devastating to the country, and congressional action could prevent that economic damage."

The amendment did not demand anything of the Senate. Basically, it said the Senate was against cancer, crime and pestilence.

Naïvely, I assumed this "vote of confidence" would readily pass and real business would then transpire. I slowly discovered how wrong I was. The "distinguished senator from Ohio," Sen. Metzenbaum, took the floor. He admitted he did not have the full facts concerning the strike issues. He admitted he had not fully looked into the situation. Yet, he argued that the strike should go on. After a while, the railroad unions and management would be unhappy with the havoc they had caused and would be willing to settle their differences. He moved to table Sen. Dole's amendment and therefore do nothing.

The vanilla amendment finally was passed, but the railroad strike did occur. I read in the *Washington Post* that Secretary of Labor Lynn Martin was not available to help settle the strike. Unfortunately, she had previously committed herself to co-hosting two television shows in California.

Maybe I caught the House of Representatives, the Senate, Vice President Quayle and Secretary Martin on an "off day." However, I do understand one thing: I cannot believe that Washington is able to solve the health care crisis.



**Stephen Boren, M.D.,** is assistant professor of emergency medicine at the University of Illinois at Chicago and a health care consultant.

## GUEST EDITORIAL

## The Rule 224 sandtrap

**L**ast April a Belleville physician and his two attorneys were jailed by a St. Clair County judge after being held in contempt of court because the physician refused to answer a question, on advice of counsel, at his deposition. James Vest, M.D., a pulmonologist and critical care physician, had been named as a respondent, along with St. Elizabeth's Hospital and six other physicians, in a petition filed under Illinois Supreme Court Rule 224 by the family of a deceased former patient.

I was retained by the Illinois State Medical Inter-Insurance Exchange to represent Dr. Vest; he also had personal counsel. Our jailing resulted from the petitioner's and the circuit court's misconstruing Rule 224 and deliberately trying to expand its interpretation. This court rule, effective Aug. 1, 1989, unequivocally states its purpose in the first paragraph: "A person or entity who wishes to engage in discovery for the sole purpose of ascertaining the identity of one who may be responsible on damages may file an independent action for such discovery."

Under this rule, a person may file a petition and conduct discovery without filing a complaint alleging negligence. In Dr. Vest's case, the petitioner's counsel refused to allow any of the other physicians who were being sued to attend Dr. Vest's deposition. When they refused to leave, the deposition was terminated, and the petitioner voluntarily dismissed those physicians to prevent them from attending. The judge then granted the petitioner's extraordinary request to compel Dr. Vest to appear at the courthouse for interrogation so that the court could rule on all defense counsel's objections. After numerous objections were overruled by the judge, Dr. Vest's personal counsel and I agreed that Dr. Vest should refuse to answer the question "Did you attempt to take a test that would culture out the bacterial infection?" We were then sentenced to the St. Clair County jail, without bail, until Dr. Vest agreed to answer the question.

The propriety of imprisoning a physician and his attorneys for making good faith objections in an effort to seek appellate review regarding a disputed point of law is of urgent concern to the Illinois medical community. Rule 224 is a sandtrap in which any health care provider in the state could suffocate.

In response to the medical malpractice crisis, the legislature in 1985 promulgated the Medical Malpractice Reform Act. The Act mandated that all medical malpractice suits be filed with a written report from a reviewing health care provider certifying that the medical records and other pertinent data indicate a reasonable and meritorious cause for filing such an action. The constitutionality of this provision was upheld by the Illinois Supreme Court.

Without question, Rule 224 does not provide for a proceeding such as the one brought against Dr. Vest to establish liability, but provides a proceeding solely to establish the "identity of one who may be responsible." Instead, Dr. Vest found himself being ambushed with questions from an attorney on a "fishing expedition" regarding the treatment of a decedent. How can a physician properly prepare for such an inquisition without knowing about possible allegations of negligence that may be brought?

Once a patient has discovered the identity of the party who may be responsible for medical malpractice, any discovery about the nature and extent of the treatment or apportionment of responsibility is beyond the intent of this rule. This was the construction given to Rule 224 by the Third District Court of Appeals in *Guertin vs. Guertin*, 204 Ill. App. 3d 527 (1990), which was the only appellate court decision on the issue facing Dr. Vest.

As a matter of judicial precedent, the St. Clair County judge was obligated to follow *Guertin* regardless of his opinion of the ruling. Yet he chose to ignore a higher court's decision, ordering Dr. Vest to answer the question, then jailing him when he refused to do so, on advice of his counsel. Without question, the petitioner and her counsel had "identified" Dr. Vest as a person "who may be responsible in damages," and they were trying to circumvent the Medical Malpractice Reform Act.

Rule 224 must be held invalid, because it is inconsistent with the Act. The statute was designed to eliminate frivolous suits by ensuring that medical malpractice actions are meritorious and are investigated before suits are filed. Unscrupulous attorneys are now turning to Rule 224 to circumvent those requirements, the effects of which will devastate the medical community.

In light of the ruling's detrimental impact on the health care community, not only were briefs filed with the court of appeals by the parties, but also *amicus curiae* briefs were filed by the Illinois State Medical Society, the Illinois Hospital Association and Memorial Hospital, where Dr. Vest is on staff.

In its *amicus* brief, ISMS stated: "To subject practicing physicians to the grossly repressive sort of attempted intimidation sought by petitioner and carried out by the circuit court will have a disproportionate and adverse effect upon all practicing physicians in the state."

Dr. Vest and counsel were released from jail by the Fifth District Court of Appeals on an emergency petition to stay the trial court's order. We are currently awaiting a date for oral argument in the Appellate Court of Appeals on the above issues.



**Charlene A. Cremeens** is an attorney with the firm of Hinshaw & Culbertson in Belleville.





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*Case in Point  
explores  
hysterectomies*

PAGE 10

# ISMIE Update

**Medical  
records  
questions  
prompt new  
brochure**

PAGE 12

## Policyholder service crucial to Claims

**SERVICE INITIATIVE:** New Claims Division service procedures exemplify the Exchange's commitment to policyholders.

[ CHICAGO ] Underscoring the new "Physician First Service" rededication to serving the policyholder, the Illinois State Medical Inter-Insurance Exchange Claims Division is bringing service to the forefront with several new service-oriented implementation plans.

"By implementing changes throughout the Exchange, we are gaining speed in attaining our goal of total service to the physician," said Harold L. Jensen, M.D., chairman of the ISMIE Board of Governors. "Policyholders own the Exchange and expect to be treated like owners. In each division, the Exchange is stressing willingness to support service."

"The changes in Claims Division procedures should bring about a vital change in the way the entire company does business," said Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors. "The

updated claims procedure manual, increased staff and better technical services have all been implemented with one goal in mind – to increase policyholder access to the Exchange in order to provide complete service beyond what has come to be expected."

Increased Claims Division staffing will make professional liability analysts available to policyholders on much shorter notice than in the past, said Dr. Boren. All insureds will have same-day contact with analysts for response on such issues as new losses, defense counsel assignment and investigation procedures.

"With greater policyholder contact, we'll be able to break down the barriers of the past," said one Exchange professional liability analyst. "Everything we're doing is for service – creating faster decision making, enhancing productivity, working on shorter notice to solve problems and answer policy-

holder questions and concerns."

"The new claims procedure manual specifies ongoing contacts with insureds on pending claims," Dr. Boren said. With more frequent updates, policyholders should feel they have greater control over their malpractice claims, which will lead to more involvement in the liti-

gation process, he said.

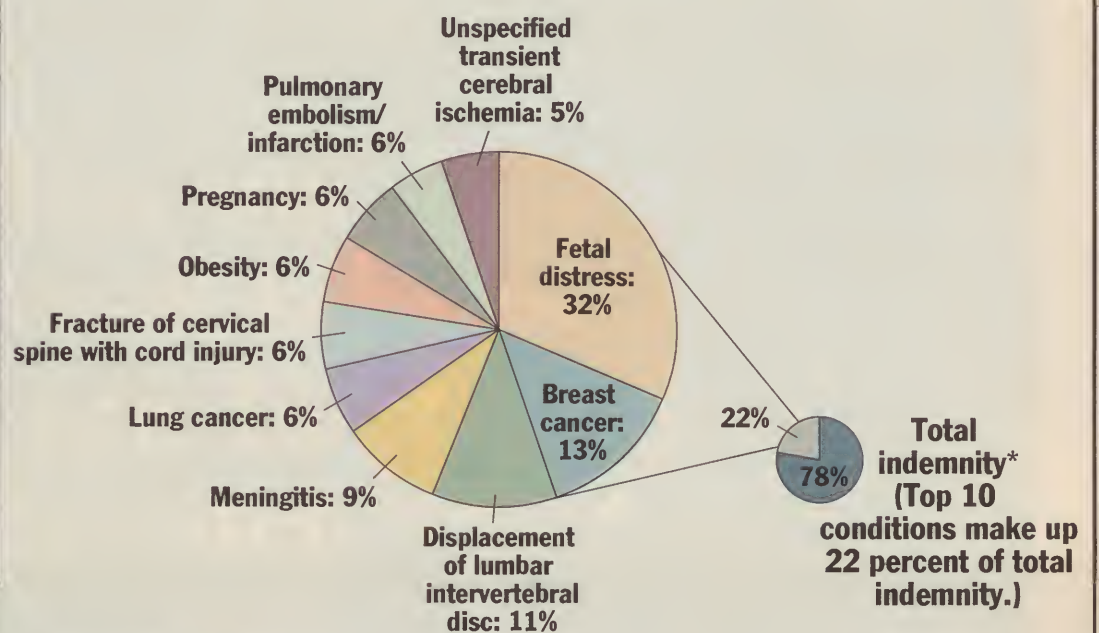
"What we are striving for is better coordination between the physician, defense counsel and the Claims Division," another analyst said. "We are becoming more and more responsive to the needs and wishes of our insureds. One way to do this is to inform all policyholders of

the Defendant Reimbursement Program."

The Defendant Reimbursement Program is a free Exchange service that remunerates physicians for income lost during attendance at deposition or trial. The service compensates currently insured policy-

(Continued on page 11)

## Top 10 patient conditions implicated in the largest ISMIE payouts



\* Paid between 1/1/85 - 6/30/92  
Source: Illinois State Medical Insurance Services

## MALPRACTICE ROUNDUP

### Patient dumping suits not subject to caps

As reported in the Bureau of National Affairs' *Health Law Reporter*, a U.S. District Court in Virginia held that under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are not protected by state medical malpractice caps in patient-dumping suits. EMTALA requires Medicare-recipient hospitals to provide medical screening and stabilizing treatment to any patient who seeks emergency room care. It also permits injured persons to seek damages for personal injury under the law of the state where the hospital is located. Virginia law does not place a limit on personal injury damages.

The court said Virginia's medical malpractice damages cap should not be "imported" into EMTALA

because the laws serve very different purposes. The malpractice cap law is intended to combat problems involving the availability and affordability of insurance for health care providers. The court argued that enforcing this law in EMTALA cases would conflict with the federal Act's intent to deter patient dumping and to compensate those who are unlawfully dumped.

### Male, female Ob/Gyns sued at same rate

A new survey released by the American College of Obstetricians and Gynecologists shows that male and female Ob/Gyns are sued at the same frequency. It is the first survey conducted by ACOG covering a large

enough sample of women to examine gender differences in malpractice experiences.

Among Ob/Gyns who have practiced less than five years, 47.7 percent of male physicians and 48.3 percent of female physicians have been sued at least once. Among those practicing for five to 15 years, 76.4 percent of males and 76.9 percent of females have experienced at least one malpractice claim.

Overall, 79.4 percent of Ob/Gyns surveyed have been sued at least once during their careers, the survey showed. This rate has steadily increased from 70.6 percent reported in 1987. In addition, a quarter of all Ob/Gyns have had four or more claims filed against them. While the figure has not increased since a 1990 survey, it has nearly doubled since 1987. New York physicians were significantly more likely to have experienced four or more claims (47.7 percent) than the total sample (24.8 percent).



## Case in Point

A regular feature using hypothetical case histories to illustrate loss-prevention maxims.

By Tony Sullivan

### Case #1

**Presenting complaint and initial diagnosis:** A 60-year-old woman was operated on for a total abdominal hysterectomy and bilateral salpingo-oophorectomy. A

Marshall-Marchetti-Krantz procedure was also performed to correct a history of urinary stress incontinence.

**The case in brief:** Within 24 hours of the hysterectomy, the patient developed a urine leak from the bladder at the vesicovaginal juncture. The surgeon who repaired the leak did not perform the original operation. He attributed the leak to ligature infringement on the bladder. Two years later the woman underwent a left nephroureterectomy and claimed that the alleged negligently performed

hysterectomy was the cause.

**The resulting claim:** The woman sued the original surgeon for negligent performance of a hysterectomy.

**The outcome of the claim:** The case was settled for \$220,000.

### Case #2

**Presenting complaint and initial diagnosis:** A 42-year-old woman with complaints of long-standing abdominal pain was operated on for a total abdominal hysterectomy. Previous pathology and many adhesions made the surgery difficult.

**The case in brief:** About two weeks after her discharge, the woman went to the emergency room of a local acute care hospital with complaints of severe abdominal pain. Yellow discharge and fecal matter drainage at the wound site indicated the presence of infection and a fistula. The surgeon recommended a fistulogram to confirm the indications and hyperalimentation therapy to permit the fistula to close, but the patient refused to consent to either procedure.

Two weeks later she consented to hyperalimentation therapy, but her pain continued. After a month, the patient switched to another surgeon, who also recommended a fistulogram and possible surgical treatment. This time the woman consented to the fistulogram, which confirmed the presence of a large bowel fis-

tula, and the surgeon performed a fistulectomy on a ruptured diverticulum without incident.

**The resulting claim:** The patient sued, claiming permanent pain and discomfort as a result of the initial surgeon's negligent performance of a hysterectomy.

**The outcome of the claim:** The case was settled for \$65,000.

**The points these cases make:** The development of fistulas in the ureter or bladder, similar to those described in these cases, are among the most serious possible complications of hysterectomies, according to Mario Yu, M.D., an Ob/Gyn from Oak Brook. Physicians can take several steps to prevent their occurrence.

The most fundamental step is to make sure hysterectomy is indicated in the first place, suggested Dr. Yu. Common indications for hysterectomy are pelvic malignancies, benign tumors, severe endometriosis, pelvic wall prolapse or bleeding that has been unresponsive to medical therapy. Also important is familiarity with areas in the operative field where problems can occur.

One such area is the pelvic brim, where the ovarian vessels cross the pelvic sidewall, said Dr. Yu. The ureters also cross here. "Sometimes when you clamp the ovarian vessels, you can damage the ureter there." Another common site of injury is where the ureters cross the uterine artery before they enter the bladder.

## YOCON<sup>®</sup> YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

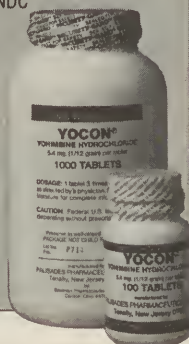
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Although injuries to the ureters can and do occur during hysterectomies, bladder injuries are more common, according to Dr. Yu. These injuries usually result from failure to completely dissect the bladder from the cervix and the lower part of the uterus. When the surgeon clamps the uterine blood vessels or the vagina during an abdominal hysterectomy, he or she may also clamp part of the bladder. This damage to the bladder wall can cause a vesicovaginal fistula, which is difficult to recognize intraoperatively, Dr. Yu said. Perforation of the bladder can also occur during vaginal hysterectomies when the bladder is dissected from the cervix.

But damaging the ureters or bladder does not constitute malpractice, Dr. Yu said. "These things can happen in the best of hands." The injuries are usually easy to repair if they are recognized

intraoperatively or while the patient is still hospitalized. But if the injuries go unrecognized, damage can occur and a medical-legal situation can result, he said.

Physicians should talk to the patient about potential risks and any complications that have occurred. Communication is essential before and after surgery.

Physicians also should be alert to patients such as the woman described in Case No. 2, who have had a Caesarean section or other previous surgery in the uterine area, Dr. Yu stressed. These patients often have dense scar tissue where the bladder was dissected from

the uterus during the C-section. Physicians should document the patient history and physical findings.

Close postoperative observation during the inpatient recovery period can usually identify these problems if they are missed intraoperatively. This is a key risk management practice physicians should follow, Dr. Yu said. It involves looking for such symptoms as fever, blood in the urine, abnormal bleeding or unusual pain. Post-discharge follow-up should also occur within one month to check on the healing of the incision and bladder area. Patients also should be queried regarding any unusual pain or

vaginal discharges, Dr. Yu added.

Although these intraoperative and postoperative preventive measures can significantly reduce the likelihood of complications and resultant lawsuits, the most important risk management step in hysterectomy operations must be taken before the surgery, according to the Exchange's risk management advisers. They recommend telling patients before surgery that this is not a trivial event and that problems can – but seldom do – result. These discussions, including the patient's understanding, should be reflected in the medical records. ■

## Policyholder service

(Continued from page 9)

holders \$500 a day and is intended to encourage physician participation in defense of malpractice cases.

"We're creating a more proactive operation where defense decisions are made earlier and the analysts will have more time to meet early with insureds and defense counsel," Dr. Boren said.

TO BETTER ADDRESS the needs of policyholders throughout the state, the Exchange will open additional offices around the state. Each will be staffed by at least two claims analysts as well as an underwriter, Dr. Boren said.

# How many doctors does it take to create one health care network?

*"While change doesn't happen overnight, the Exchange is committed to complete implementation of the 'Focus on Service' initiative in 1993."*

**HAROLD L. JENSEN, M.D.**  
**CHAIRMAN OF THE EXCHANGE**  
**BOARD OF GOVERNORS**

"Exchange insureds are not all from Chicago," Dr. Jensen said. "It is important that as a statewide physician-owned company, the Exchange gives personal service to all policyholders. Physicians in Springfield have been pleased with the service they receive from our Springfield claims analysts. We will extend this service to other communities in Illinois to better attend to the needs of our insured physicians.

"Implementation of change is an ongoing process," Dr. Jensen continued. "While change doesn't happen overnight, the Exchange is committed to further acceleration of the 'Focus on Service' initiative in 1993. We believe in sound business practices, but policyholders should think of their policies as a service rather than a product. We're here to listen and respond to our physician-owners' concerns." ■

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# Medical records questions prompt new brochure

**MEDICAL-LEGAL:** Physicians will receive "A Physician's Guide to Medical Record Access and Retention" with the next issue of *Illinois Medicine*. By Anna Brown

[ CHICAGO ] What legal question do doctors ask most frequently? It is one you yourself may have asked: How long do I have to keep medical records in my office?

The Illinois State Medical Society will distribute the new brochure "A Physician's Guide to Medical Record Access and Retention" with the Dec. 4 issue of *Illinois Medicine*. The brochure, covering consent issues as well as patient record access and retention, is a comprehensive guide for answers to physicians' questions about medical records.

Based on ISMS' *Medical Legal Guidelines* with input by ISMS legal counsel, the brochure also contains risk management information vital to all Illinois State Medical Inter-Insurance Exchange policyholders.

In addition to questions about retention, the following are commonly asked and are answered in the brochure:

1. *What information should I release when I receive a request for office medical records?*

Information subject to release consists of all information relative to the diagnosis, treatment, prognosis, history, charts, pictures and plates kept in connection with a patient's treatment, whether or not the material is in the patient's actual medical record. Financial (billing)

records are not subject to release. The original records should not be released except in response to a court order other than a subpoena, or at the request of a physician's defense counsel when the record is involved in litigation. Instead, copies should be made of all materials.

2. *Are records prepared by other physicians considered part of the medical record?*

If secondary records from other providers are a part of the patient's entire record, they are subject to release without disclaimer.

3. *What right do patients have to medical records held by their physicians?*

Generally, upon receiving a patient's written request, physicians are required by law to provide medical records to an attorney or other physician.

Physicians are not required to release medical records to patients. However, denying patient access could jeopardize the physician-patient relationship, creating potential liability hazards. From a risk management standpoint, physicians should make medical records available to patients upon written request, unless there are extenuating circumstances.

4. *Can I refuse to give medical record access to patients with outstanding bills?*

No. Any authorized request for a patient's medical record must be hon-

ored within 60 days of receipt. A physician may not withhold medical records because a patient fails to pay for services.

5. *Who may consent to access medical records?*

A physician must obtain consent to release medical information from the patient or the patient's applicable legal guardian, parent, estate administrator or agent/surrogate. Minors may also consent to medical record access if they are

- married or formerly married;
- pregnant;
- parents;
- emancipated;
- 12 years old or over and seeking treatment for alcoholism, drug use, venereal disease, mental illness, developmental disabilities or a member of a family in which another member abuses drugs or alcohol;
- seeking treatment for sexual assault or abuse.

Minors may also consent if they are seeking birth control services and are married, parents or pregnant; have consent of their parent or legal guardian; were referred by a physician, clergyman or planned parenthood agency; or would face a serious health hazard because of failure to receive such service. ■

## EXCHANGE Q & A

**Q. I am considering accepting a position in a government agency. How will this change my Exchange policy?**

A. Certain underwriting rules apply to physicians who work for federal or state government. The Exchange covers governmental medical practice activities as long as the services are independently contracted and amount to 25 percent or less of the physician's insurable practice time. Physicians who render professional services to referral patients in their own offices or in nongovernmentally owned hospitals while under independent contract to a government agency, institution or facility may be covered even though the activity exceeds 25 percent of the physician's insurable practice time.

Physicians who practice medicine as employees of government agencies, institutions or facilities are not eligible for Exchange coverage. However, physicians may purchase coverage from the Exchange to cover their private practices outside of uninsurable governmental practice employment.

## Tailored Health Benefi





## Would you support a ban on smoking in indoor and/or outdoor stadia?

Several of the respondents to Snapshot were smoking when Illinois Medicine approached them on Michigan Avenue in Chicago. Most asked that Illinois Medicine not identify them as smokers.



**Rob Hildebrand**  
Street maintenance worker  
Chicago

It doesn't bother me, either way. It would be a little more fair to ban smoking indoors and not outdoors. Smoking stinks. I shouldn't smoke. I deal with people all day who don't smoke. It's a bad habit I've got to get rid of. My dad just went in [to the hospital] for heart problems. He smoked for over 20 years, and he quit over 15 years ago, and he's still recuperating from the tar buildup. It's not a good habit.



**Pam Heiligenthal**  
Student  
Chicago

I definitely believe that smoking shouldn't be allowed in public areas. I am a smoker, but I really don't feel there are a lot of areas where smoking should be allowed. Even outdoors you should watch where you're smoking so you don't intimidate people. Secondhand smoke affects people both indoors and outdoors.



**Lisa Lawson**  
Package designer  
Chicago area

I think it would be wonderful, fantastic. Why should nonsmokers be exposed to the smoke of others and potentially be exposed to a number of diseases?

Smoking should be banned both indoors and outdoors. Even when I'm sitting outside at a game there's smoke blowing in my face.



**Bob Reed**  
State employee  
Markham

I certainly would. Smoking is bad for everybody, and secondhand smoking, as they call it, is even worse. They should ban cigarettes, period. We need to put the tobacco companies out of business. Smoking, dipping or whatever.

It's bad for the health. Banning smoking in indoor stadiums would be a foot in the door, so to speak.

Interviews by Anna Brown. Photos by Wm. Daniels/The Photo Partners.

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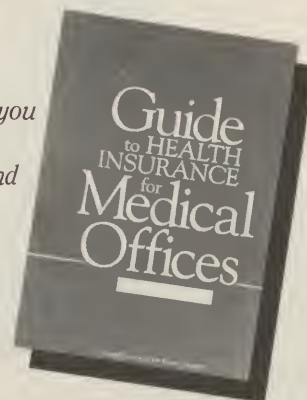
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## SMOKING IN STADIUMS

# Are they smoking in Skydome?

*Fans weren't lighting up as they waved their foam rubber "J"s during baseball's World Series, but what about in other championship stadiums? Illinois Medicine asked the world champions about their smoking policies, and surveyed stadiums and sports arenas throughout Illinois as well.*

BY ANNA BROWN

**S**ummer is definitely over. Already, all over the state and the country, people are huddling together once again, shivering on the street corner, out in the parking lot or down the street at Wendy's. They are the employees who work in buildings where smoking has been banned.

This scenario takes place every workday, during business hours. On weekends, however, smokers and nonsmokers alike head for their favorite sports events in stadiums, arenas, fields, parks, speedways and rinks. Some stadiums are open-air, some are closed, but most hold thousands of fans.

Smoking regulations vary from stadium to stadium. Many indoor arenas don't let fans smoke in their seats, but do not ban smoking altogether. Smoking is seldom restricted at football games, but some baseball teams are taking smoking seriously to reduce the health hazard to their fans.

The American Medical Association recently wrote to owners of major league baseball teams asking them to ban smoking at their games. The AMA urged the owners to protect "players, employees and fans from needless exposure to the 4,000 chemical toxins in tobacco smoke." Some teams in a variety of sports seem to be heeding such warnings, but attitudes in sports still vary widely. *Illinois Medicine* surveyed smoking policies in Illinois stadiums and stadium policies for some of the 1992 world champions.

## The world champions

Illinois was lucky enough this year to have its own world champion team – the Chicago Bulls. Tickets were almost impossible to come by, not only for the championship series, but for playoffs and regular season games as well.

The Bulls and the Chicago Black Hawks hockey team play home games at the Chicago Stadium. Fans of both teams must heed a common smoking rule: no smoking except in the lobby.

"We have signs all over the building and make announcements over the PA system," said Don Murphy, stadium publicity direc-

tor. "This rule has been in place at least 20 years."

Murphy added that the stadium has received complaints about the smoking rule, but he shrugged them off by saying, "People are always complaining." He doesn't think legislation banning smoking in stadiums is necessary because it would be too difficult to enforce. "Chicago Stadium holds 18,000 people. To enforce a smoking law we would need 18,000 policemen."

Skydome in Toronto is home to the new baseball world champions. The Blue Jays, the first Canadian team ever to win the World Series, play in the ultramodern, three-year-old stadium that is sometimes open air and sometimes indoor. Seating 51,000 fans, Skydome allows smoking only in concourse areas, whether the roof is open or closed. However, effective Jan. 1, 1993, a Toronto city ordinance bans smoking in all municipal buildings, including the stadium. The Skydome complex also includes several restaurants and a hotel where smoking is permitted in designated areas.

"Players don't smoke in the clubhouse," said Skydome spokesperson Janice Davidson, but she said she was unaware of any rule banning smoking in the dugouts or clubhouses. There have been complaints about smoking in the concourses, she acknowledged. "Smoke drifts over the seats by the concourses when people congregate. We've received calls about it."

Hank Abate, Pittsburgh Civic Arena assistant general manager, found it "very unfortunate" that his stadium allows smoking in its concourse areas, although no smoking is allowed in seating areas. Civic Arena is home to the Stanley Cup-winning Pittsburgh Penguins. Abate said the rule has been in place for all 30 years of the arena's existence.

Abate said he would welcome any new legislation governing smoking in stadia. "It's absolutely terrible in the concourses," he said. "We've had several complaints."

Civic Arena shies away from banning smoking altogether because the facility belongs to the county, Abate said. But he feared that without legislation, a complete smoking ban could



## SMOKING IN STADIUMS

**C**hicago Stadium holds 18,000 people. To enforce a smoking law we would need 18,000 policemen.

— Don Murphy  
Chicago Stadium publicity director

said Mark McGuire, executive vice president of business operations for the Chicago Cubs. In 1992, there were no restrictions on smoking in public areas of Wrigley Field, McGuire said. In the offices and press box, however, smoking is banned.

"We have some 'old school' cigar-smoking writers who took exception to the rule at first," McGuire said. "But we held our ground."

The Cubs recently surveyed season ticket holders asking for opinions on smoking policies. "We want to know what fans think," McGuire said. They also consulted with major league baseball teams that restrict smoking.

Across town on Chicago's South Side, Comiskey Park Vice President of Stadium Operations Terry Savarice said the White Sox have no plans to implement a no-smoking policy. "People don't like to be told what to do," he said, adding that the stadium has received more complaints about smoking restrictions than about smoking. Comiskey Park allows smoking in all open areas, including concourses and seating areas. No smoking is allowed in closed concourses or elevator areas.

The Chicago Park District runs Soldier Field, where park supervisors designate indoor patron and employee smoking areas, said spokesperson Regina Hayes. While watching the Chicago Bears' season slip away, fans in the open-air stadium are allowed to smoke.

#### The minor leagues

Minor league baseball's 'single A' Midwest League has five teams that play home games in Illinois stadiums. These teams are community based and take great pride in providing quality entertainment to their fans. This includes making sure they are comfortable and safe while attending games.

The extremely popular and profitable Peoria Chiefs franchise, affiliated with the Chicago Cubs, accommodates 6,000 fans at the brand-new Pete Vonachen Stadium. Currently, the stadium has a 500-seat, no-smoking, no-alcohol family section, which debuted in 1991. These are "choice seats, some of the best in the ballpark," said Chiefs General Manager Mike Nelson. The section has had a "tremendous response" from fans, he said, and the park will increase such seating if there is a demand. "We really enforce [the smoking ban]," he said. "It's very beneficial for everyone."

Nelson said there are no plans to ban smoking outright at the stadium. "Most of our season ticket holders are smokers, so we don't want to upset them."

In southern Illinois, St. Louis Cardinal fans need not cross the Mississippi to see prime Cardinal baseball. The Springfield Cardinals, like their parent team, are owned by the Anheuser-Busch Co., and consequently are strongly committed to promoting and upholding the "Know When to Say When" campaign for drinking and smoking, according to Lee Landers, vice president of the St. Louis Cardinals, who also runs the Springfield team and eight other minor league franchises around the country.

The Cardinals have a 307-seat, no-smoking, no-alcohol section on the home team side of the field. "We do as good a job of policing the section as we can to make sure no one smokes or drinks," Landers said. "We take it very seriously. Maybe we're a little more forceful than other clubs, but that's the image we

not be enforced. "People need to be fined; that's the only way to do it," he said.

#### Chicago's own

Wrigley Field, Comiskey Park, Soldier Field and Chicago Stadium — these are where Illinoisans go to see their favorite professional teams.

Of all of them, Wrigley Field is closest to banning smoking, since stadium officials will decide on a new policy within the next month,

want to portray."

In fact, any vendor caught selling beer in that section "doesn't have to ask why he's lost his job," Landers said.

Another team with a no-smoking, no-alcohol section is the Kane County Cougars, now affiliated with the Florida Marlins expansion club. General Manager Bill Larson said he has heard complaints about smoking in the stands, but people are "not irate" about it. During one home game, however, Larson said he ejected three cigar smokers after receiving complaints from nearby fans. The smokers refused to move to other seats and were being "awfully difficult," so Larson returned their money and escorted them out of the park. "Cigar smoke has a definite effect on people, more so than cigarettes," Larson said.

#### The colleges

Northern, Southern, Eastern and Western Illinois universities have similar smoking policies in their indoor and outdoor stadiums. Football stadiums at all four colleges are open-air and do not restrict smoking.

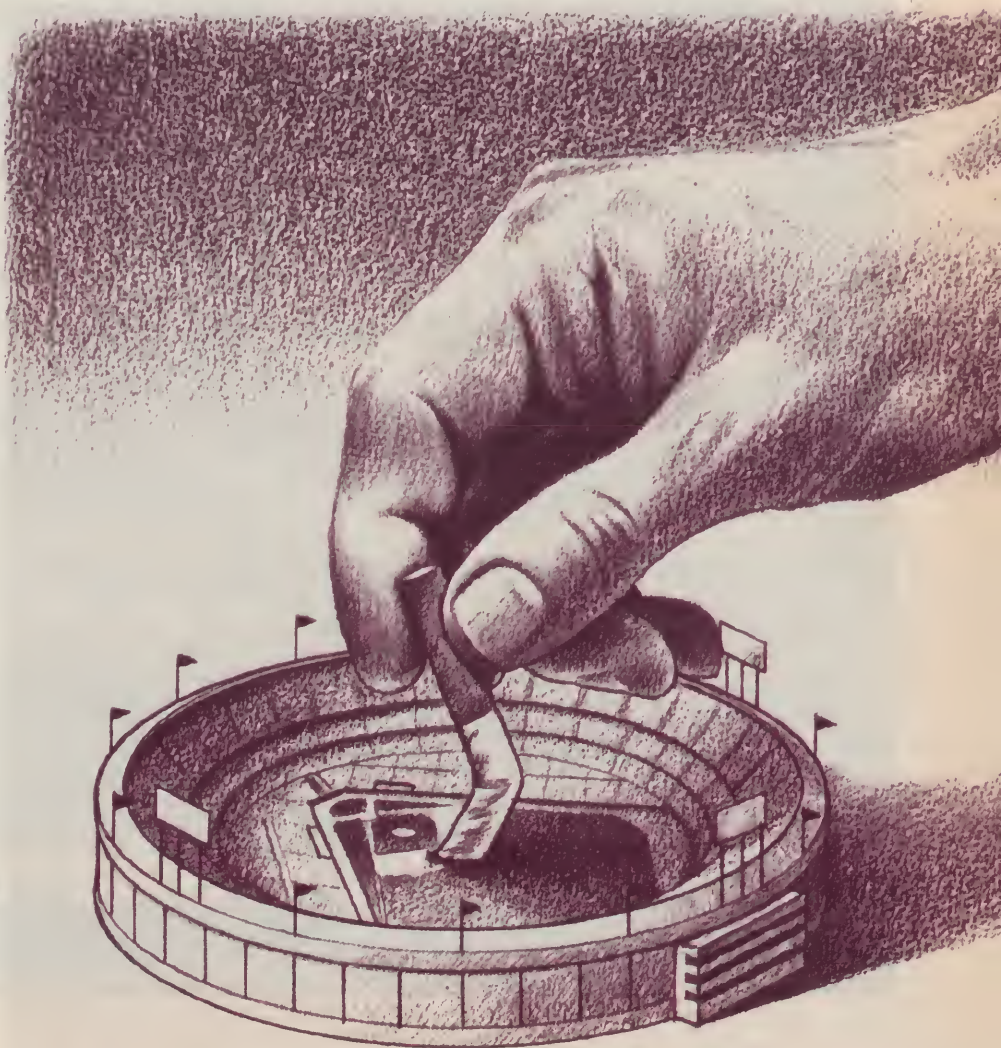
At Northern's Evans Field House, where the Huskies play, fans must abide by the campus no-smoking policy, with a designated smoking area. Pat Hewitt, associate vice president for business operations, said 12 smoke filters were recently installed in the smoking area after requests to make the building smoke free. Western Hall, where WIU's Leathernecks play, has one smoking area near the outside doors. The SIU Arena, home to the Salukis, will become completely smoke free, along with the rest of the campus, in 1995. Walter Lowell, former EIU dean, was "very opposed to smoking," and the Lantz Building, where EIU's Panthers play basketball, has been smoke free for 10 years, said Ron Paap, associate athletic director. "The majority of fans seem to enjoy the smoke-free atmosphere," he said.

At the University of Illinois at Urbana-Champaign's open-air Memorial Stadium, where the Fighting Illini play football, stadium director John O'Donnell said that when they clean up after games there is more evidence that people brought in their own alcohol — which is not allowed — than that people smoked. The stadium bans smoking only in restrooms.

Assembly Hall, the imposing dome where the Illini play basketball, is the former home to "Flying Illini" stars like the National Basketball Association's Kendall Gill and Nick Anderson. At

(Continued on page 16)

ILLUSTRATION: KEN SIMPSON







**November Employee of the Month  
Shari Goodfield.**

## Weekend, evening work earns claims supervisor November Employee of the Month award

[ CHICAGO ] If you are an Illinois State Medical Inter-Insurance Exchange policyholder and receive weekend and evening telephone service calls about your claim, chances are they're from November's Employee of the Month Shari Goodfield. A newly appointed claims supervisor for the downstate area, Goodfield received this month's commendation for her dedication to physician policyholders during a Nov. 2 presentation at Illinois State Medical Soci-

ety headquarters in Chicago. She is the second Springfield office employee to be honored this year.

Goodfield is "committed to serving members, policyholders and internal staff," said Tim Saunders, Illinois State Medical Insurance Services vice president of claims. "She demands an above-average work product for herself and encourages all who work with her to aim for higher-than-average results through hard work and dedication to

the job.

"She is known for her extensive travel and late evening and weekend conferences with insured physicians and defense attorneys," Saunders added.

Making herself available to Exchange policyholders any time of the day or night, seven days a week, is an important aspect of her job, Goodfield said. "I encourage physicians with any question whatsoever to call me at any time," she said. "I frequently give out my home number to physicians."

Goodfield said she tries to attend all meetings – even the initial contact – with the physicians with whom she works. "I believe the physicians develop a relationship with their claims analyst, and I think it's important to be present from the beginning," Goodfield said. "I am their friend and offer a listening ear or whatever they need, since often they are feeling depressed."

Goodfield joined the Exchange in 1989 as the sole claims analyst for downstate Illinois. She was promoted to claims supervisor Nov. 1.

All permanent, full-time ISMS/ISMIS employees – except senior management – are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■

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## Smoking in stadiums

(Continued from page 15)

Assembly Hall, there are currently four designated smoking areas. This policy has been in place for two years, according to director Wayne Hecht, and was instituted by the chancellor due to fan complaints about smoking.

The University of Illinois at Chicago Pavilion bans smoking in concourses and restrooms, said director Patricia Nelson. Event coordinators may also request a total smoking ban for a particular event.

Some of Illinois' private colleges have strict no-smoking policies. Northwestern University bans smoking in all campus buildings, including Dyche Stadium and Welsh-Ryan Arena. "People smoke anyway [in Dyche Stadium]," said Jack Freeman, director of operations and facilities. Since NU football games are rarely sold out, "there's plenty of room to spread out," he said.

Illinois Wesleyan University also has a no-smoking policy in its buildings. In the outdoor football stadium, however, smoking is allowed. "I recall sitting in the stands [at a football game] recently," said Athletic Director Dennie Bridges. "A guy was smoking a cigar and I was dodging his smoke. Until then I had never thought about the need for a policy for outside, because I thought the air just took the smoke up and out."

Both DePaul and Loyola University basketball teams play home games at the Rosemont Horizon, where a no-smoking policy has been in place since the stadium opened in 1980. The policy applies to all teams that play here, said Steve Grossman, Horizon marketing director. "The policy is in place for safety reasons, not for comfort," he said. ■

Gina Kimmey, Lynn Koslowsky and Tamara Strom contributed to this article.





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## Power shifts in Illinois General Assembly

(Continued from page 1)

in the Illinois House, Republicans still wrested Speaker Michael Madigan's iron-fisted, veto-proof 72-seat majority from his grasp.

While the nation and most of the rest of Illinois remained firmly in the Democratic column, GOP Senate candidates prevailed in a number of closely watched contests. Of the 12 tight Senate races examined by *Illinois Medicine* in its pre-election coverage, 10 went to Republicans. Winners included incumbent Sens. Walter Dudycz in the 7th District and Robert M. Raica in the 24th, the only two Senate Republicans whose districts encompass parts of the city of Chicago. Incumbent Sens. Ralph Dunn of DuQuoin and Frank C. Watson of Greenville also won re-election in the

55th and 58th Districts, respectively.

Moving to the Senate from the Illinois House were Republican Reps. J. Bradley Burzynski of Sycamore in the 35th District; Todd Sieben of Geneseo in the 37th District; Dan Cronin of Elmhurst in the 77th District, who easily defeated incumbent Rep. Ted E. Leverenz of Maywood; and Karen Hasara of Springfield in the 50th District. New freshman senators profiled by *Illinois Medicine* include Patrick J. O'Malley of Palos Township in the 18th District and Dave Syverson of Rockford in the 34th District, who defeated incumbent Democrat Joyce Holmberg, also of Rockford.

**IN A MAJOR SENATE** upset, Democrat Rep. Grace Mary Stern of Highland Park nar-



David K. Deets, M.D.

rowly defeated longtime incumbent Republican Sen. Roger A. Keats of Kenilworth in the 29th District. In the 43rd District, incumbent Democrat Sen. Thomas A. Dunn of Joliet held on to his seat, defeating former Republican Rep.

Charles "Chuck" Pangle of Kankakee.

Republican efforts to capture the 60 votes needed to control the House fell short. *Illinois Medicine* had identified 21 key races for its pre-election coverage. Of these, Republicans won 10 seats. In a House race of special interest to physicians, incumbent Rep. David K. Deets, M.D., of Dixon, the only physician currently serving in the General Assembly, lost to Pennie L. von Bergen Wessels, also of Dixon, by 385 votes.

**ONE SURPRISE IN ILLINOIS** congressional contests was Rockford Republican challenger Donald Manzullo's victory over 16th District incumbent U.S. Rep. John W. Cox Jr., who during his campaign announced his conversion as a supporter of caps on noneconomic damages in malpractice awards. Chicago physician Herbert Sohn, M.D., was defeated for the fifth time by longtime 9th District Democrat incumbent U.S. Rep. Sidney R. Yates.

## Blue Cross survey

(Continued from page 2)

Rather, most [favored] more than one of the alternatives offered."

At least two-thirds of respondents favored one of three mechanisms to fund a national health care system. These include premiums shared by businesses and individuals, with tax incentives provided (74 percent); taxes levied on companies that do not provide insurance for employees (66 percent); or government-provided vouchers to low-income residents to purchase health insurance (66 percent). Only 33 percent of those responding favored increasing income taxes.

To control health care costs, 90 percent of those polled said more managed care networks in which insurance companies, doctors and hospitals work together to contain costs was the way to go. About two-thirds supported overhauling malpractice awards to limit judgments (68 percent) or approved establishing a federal health insurance board to set spending goals (63 percent). About half said the government should run the system and set budgets for doctors and hospitals (51 percent) to control costs.

The survey also revealed that more than half of Illinois adults under 40 and 54 percent of residents earning less than \$25,000 a year say they have postponed seeing a physician because of cost. Overall, 44 percent of all Illinois adults questioned say costs have kept them from seeing a doctor. ■

## Voters OK universal health care referendum

A referendum supporting a single-payer, government-run health care system for the United States won voter approval on six ballots, including Cook County. Cook County voters approved the concept 1,063,637 to 327,067. Voters in Granite City (Madison County), East St. Louis, Hanover Park (DuPage County), Channahon (Will County) and North Chicago (Lake County) all supported the concept by wide margins.

The advisory referendum asked: *Should the U.S. Congress and the President of the United States enact a publicly funded National Health Insurance Program that provides comprehensive health care for all citizens while giving everyone the right to choose their own hospital, doctor or other health care professional?*

Proponents of a single-payer system are expected to use the referenda results to bolster future attempts to pass such legislation. ■

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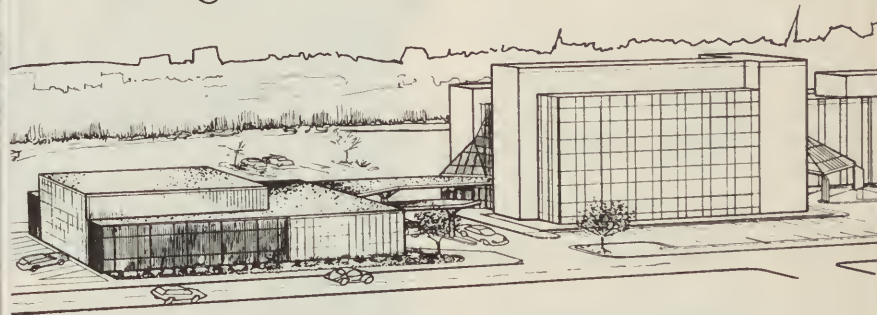


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## Access committee addresses rural health needs

(Continued from page 1)

"Guide to Rural Health Resources," covers everything from state and federal agencies to Illinois medical schools and funding sources.

"The pressure is building in Illinois and across the country to correct this problem," said George T. Mitchell, M.D., of Marshall, co-chairman of the committee. "All of the groups working to help solve the shortage agree that the problem must be resolved by local people and not by edict from the government. In other words, to be successful, the people must have the final say in solving the problem rather than having the government come in and tell them what to do."

To that end, the committee is also establishing a speakers bureau of physicians who can address community groups on how to increase access to medical care. Speakers will be available to work with medical societies and community groups to define the access problem in a particular area and to develop strategies to address the problem.

Dr. Mitchell cites several reasons contributing to the manpower shortage in rural areas.

"The malpractice situation has definitely contributed to this problem," he said. "The inordinate number of suits filed and the awards reaching into millions of dollars have resulted in excessive premium rates – as much as \$100,000 a year in some cases." Sparsely populated rural areas cannot provide the caseload necessary to cover such costs.

"The outstanding education debts of doctors starting their practices also figures into this equation," Dr. Mitchell said. "Communities that want to attract young physicians might consider providing assistance in repaying that debt for the doctor."

**ALSO CONTRIBUTING TO** the problem are the growing number of specialists and the declining number of primary care physicians, he noted.

"The health care delivery system is changing. The day of the solo family practice in every village is coming to be a thing of the past," Dr. Mitchell said. Communities that want to attract – and keep – physicians will have to consider the needs of the doctor and the doctor's family, as well as the community's needs.

"Doctors, like everyone else, must have some time off. [They] need access to continuing education in order to keep up with rapidly increasing medical technology and treatment," Dr. Mitchell said. "Schools and access to recreational and cultural activities are also important. The community must work extra hard to make the doctor and his family feel welcome."

When the malpractice crisis of the '70s and '80s drove high-risk specialists like obstetricians from rural areas, the family physicians who stayed behind found themselves responsible for more and more complex care, often without a back-up specialist to call on, if needed. In addition, as the recession tightened its grip on the farming industry, the failing economy took its toll on small local hospitals, and rural populations found themselves miles away from physicians and from hospitals.

"There are some 15 counties in rural

Illinois without a hospital, [and] there are no obstetricians practicing in 48 rural counties of Illinois," Dr. Mitchell said. "And there are no hospital obstetrical units in 40 rural counties, due to there being no hospital or the hospital's discontinuing obstetrical services."

Innovative solutions to increasing access range from the long-term solution of "growing your own" physicians, encouraging young people in the community to consider medicine as a career

(and their hometowns as ideal practice sites) to expanded rural health care curricula in medical schools that would expose today's medical students to the benefits of this kind of practice.

"There is considerable interest ... concerning regionalization in rural areas," Dr. Mitchell said. "The concept that makes sense to me would be a primary health care center completely equipped with x-ray and laboratory services, physical therapy and other appropriate ancillary services, with offices and examining rooms for several family physicians. The center would be linked to a hospital or hospitals by a good transportation sys-

tem – ambulances and, in some cases, helicopters."

Looking into the future, Dr. Mitchell anticipates the increased use of telecommunications for sparsely populated areas, connecting patients in primary care centers with specialists far away through television technology.

"This concept is already in place and operating in some areas," he noted.

For more information and a copy of the booklet "Rural Health: Reaping the Benefits of Community Action," call the ISMS Division of Health Care Finance at (312)782-1654 or (800) 782-ISMS. ■

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## Governor appoints health care task force

(Continued from page 1)

panel will be health care providers, hospital and long-term care industry officials, state legislative leaders, business representatives, academicians, and several members-at-large with an interest in improving Illinois' health care system.

"We are bringing together a rare blend of experts — including those who provide health care, those who pay for it and leading academicians — to help us chart a strategy for improving access and containing costs," Edgar said. The directors of Illinois' departments of Public Health, Public Aid, and Insurance; the Health

Care Cost Containment Council; and the governor's top health and legal aides will work with the task force, Edgar added.

Creation of the task force was prompted by a summer legislative compromise reauthorizing the state's Medicaid hospital assessment program. In selecting its members, Edgar charged the group with making recommendations to improve the Illinois Medicaid system.

"The task force initially will focus on how we can best meet the state's responsibility to provide health care to the poor," he said. The governor said he expects the group's Medicaid suggestions on his desk by Feb. 1 to "allow ample time for the General Assembly to consider any legislation we propose as a result of the task force recommendations."

Among expected recommendations is the task force's analysis of whether the state should continue the assessment program — which this year will reap \$735 million in federal funds — or investigate other funding sources. In agreeing

*"We are bringing together a rare blend of experts ... to help us chart a strategy for improving access and containing costs."*

GOV. JIM EDGAR

to the compromise in July, hospital and long-term care facilities held firm to their position that the assessment program should be temporary and that the state should identify alternate funding mechanisms for Medicaid. The assessment program does not directly affect physicians.

In addition to addressing Medicaid problems, the panel also may branch out to offer recommendations on "broader concerns dealing with access and cost," Edgar noted. In response to the governor's invitation, ISMS will share its

members' work in health care reform.

For example, the Society will bring to the table the ISMS Ten Principles of Health Care Reform, a platform for addressing the ills of the current health care delivery system. ISMS cites Medicaid program changes as an area critical to achieving meaningful reform. Physician representation also will update the task force on the progress of an ISMS plan aimed at removing access barriers in Illinois. The Society's Third Party Payment Processes Committee is considering development of a proposal for potential legislative consideration.

Edgar added that the task force will not operate in a political vacuum. "Other issues — and perhaps even the Medicaid assessment program — may be impacted by action at the federal level, because President-elect Clinton has pledged to make health care reform a major and immediate priority for his new administration," he explained. "So, the task force obviously will do its work within the context of what is happening at the national level." ■

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Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654 from 8:30 a.m. to 4:45 p.m. Monday through Friday.

In addition, ISMS President Arvind K. Goyal, M.D., is available for calls the first Wednesday of every month at extension 1333. ■

## President vetoes Medicare changes

(Continued from page 1)

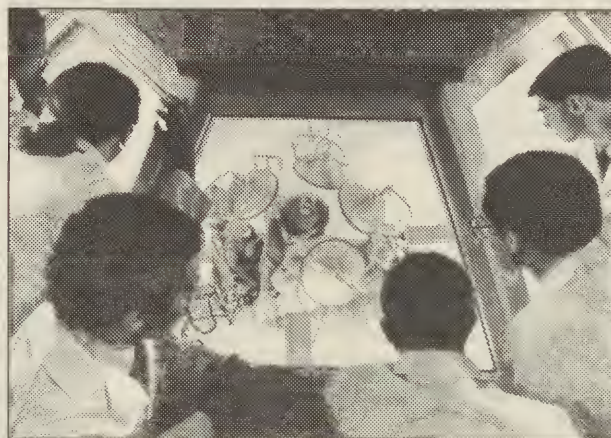
Medicare program amendments, stating in his veto message that the bill contained tax increases and provisions that would undermine small businesses," the AMA said. In a communique to state medical societies, the AMA called the Medicare changes "priority" program amendments.

Specifically, these amendments to the RBRVS Medicare payment schedule would have reduced administrative hassles, eliminated the payment rate disparity between new physicians and physicians practicing more than three years, and restored Medicare reimbursement for physicians' interpretation of EKGs. Both the new physician and EKG increases were structured to be budget-neutral, offset by corresponding decreases in other payments to physicians. The

AMA provisions also called for use of more accurate data in determining geographic practice cost indices. These GPCIs influence physicians' reimbursement rates for Medicare services by calculating the overhead, cost-of-living and professional liability costs for the region in which they practice.

The AMA has already begun contacting key lawmakers and staffers on Capitol Hill to put these issues back on Congress' agenda. The AMA hopes these Medicare modifications will be passed by the next Congress, since President-elect Bill Clinton "seems to want to work on health care," an AMA spokesperson told *Illinois Medicine*. ■

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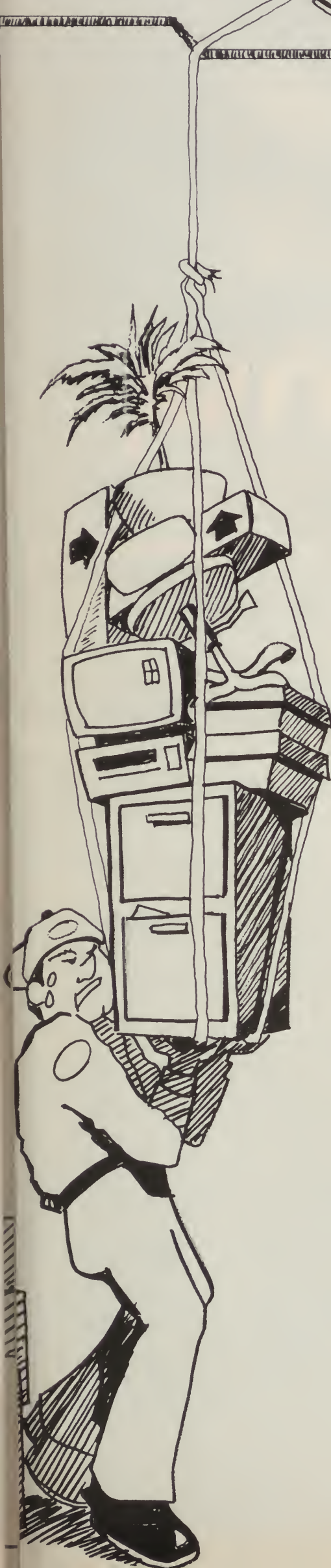
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For the many faces of mild hypertension

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‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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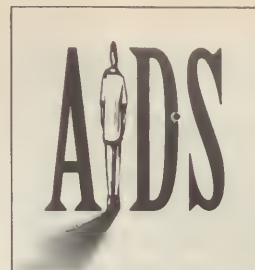


ISMS residency  
directors'  
seminar focuses  
on candidate  
evaluation

PAGE 5

# Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • DECEMBER 4 1992



One physician's  
struggle with HIV

PAGE 12

## Legislative changes make health care policy changes difficult to predict

### ELECTION ANALYSIS:

Republicans gain a majority in Senate, five seats in House. By Kevin O'Brien

[ SPRINGFIELD ] The post-election Illinois Senate shift to the Republicans – like the national shift to Democratic power – portends some change in state health care policy. But the degree and nature of that change is speculative, at best.

"We hope that the state legislative election results will bring balance back to the legislative process, reversing its recurring dominance by plaintiff attorney interests," said Arvind K. Goyal, M.D., Illinois State Medical Society president.

Certainly the new 32-27 Republican majority in the Senate, which all but ensures that Sen. James "Pate" Philip of Elmhurst will succeed retiring Senate President Philip Rock of Oak Park as head of the upper chamber, produces a more congenial atmosphere for physician-oriented issues, observers say.

But the House of Representatives remains a formidable obstacle to issues such as tort

(Continued on page 5)

## INSIDE

Deere & Co.  
poised to open  
health center

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## Insurance plans offer HIV coverage for physicians and health care workers

**HIV COVERAGE:** Open enrollment for physicians and medical students is on for the AMA-sponsored HIV Indemnity Plan, while a Boston firm offers hospital coverage for health care workers. By Kevin O'Brien

[ CHICAGO ] Physicians, medical students and residents who are concerned they might be exposed to HIV in the course of their work or studies may wish to consider an HIV indemnity plan offered through the American Medical Association's wholly owned subsidiary, the AMA Insurance Agency.

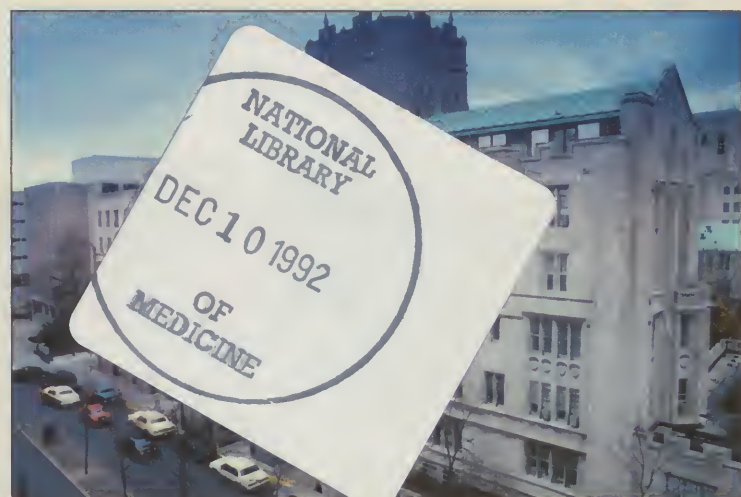
Annual open enrollment for the plan began Oct. 1 and will continue until March 1, 1993. The plan provides lump sum benefits of \$500,000, \$250,000 or \$150,000 for practicing physicians; \$250,000 or \$150,000 for resident physicians; and \$50,000 for medical students. Annual premiums are \$940 for the \$500,000 benefit; \$480 for the \$250,000 benefit; \$295 for the \$150,000 benefit; and \$90 for the student \$50,000 benefit. Coverage is available to AMA members and nonmembers, although nonmembers are assessed an annual policy fee of \$45 for physicians and residents, and \$20 for students.

Benefits are not contingent on the insured's manifesting the end-stage symptoms of AIDS, according to the AMA. Instead, if an insured is infected after the effective date of insurance, a

lump sum of the benefit selected during application is paid. Insureds may use the benefit any way they wish. Benefits and rates are individually guaranteed renewable for five years

and are not based on age, specialty, gender, income or geography. A blood screen is required at the time of application.

For more information, call  
(Continued on page 18)



The University of Chicago Medical Center.

## Circuit appeals court holds U. of C. Hospitals responsible for death of bypassed patient

**BYPASSING:** The recent decision raises the question of whether COBRA statutes apply in a pre-hospital setting. By Stacie Crozier

[ CHICAGO ] The University of Chicago Hospitals has asked a federal appeals court to reconsider a decision that could hold hospitals responsible for emergency care patients before they ever reach the ER doors.

A Chicago 7th U.S. Circuit Court of Appeals decision clears the way for the family of Lenice Nelson to pursue a private action against the South Side hospital.

In February 1990, the infant

was re-routed to St. Bernard Hospital, after the U. of C. facility indicated it was on bypass status and couldn't take the child, who had arrested. However, St. Bernard lacked the pediatric intensive care bed she required, so she was transferred to Cook County Hospital, where she died.

The child's family sued the University of Chicago Hospi-

(Continued on page 18)

## ISMS PERSPECTIVE

## ISMS PHYSICIANS CONTINUE TEEN HEALTH EDUCATION EFFORT

Just when you thought the news about AIDS couldn't get worse, a new study is released showing the number of AIDS cases among teens and young adults has increased 77 percent in the past two years. This astounding increase proves that early AIDS education efforts for our younger population have been inadequate. Four years ago, however, the Illinois State Medical Society decided to take an active role in educating Illinois teens about this

deadly disease through the development of the "AIDS and Adolescents" outreach program.

The program, developed during the presidency of Edward J. Fesco, M.D., sends volunteer physician speakers into local junior and senior high schools and community groups to alert teens to the risks of AIDS transmission in early sexual activity and drug abuse.

"Adolescence is a time of experimentation  
(Continued on page 17)



## Most Americans are not practicing 'safe sex'

[ WASHINGTON ] Most Americans are not practicing "safe sex" and as a result are risking HIV infection, according to the authors of the largest national sexual survey in four decades. Survey results, published in the Nov. 13 issue of *Science* magazine, indicate the majority of heterosexual Americans with multiple partners engage in sexual intercourse without condoms.

For the survey, more than 10,000 Americans were questioned by telephone about their sexual practices. Respondents were selected by a random-digit dialing system and represented people between the ages of 18 and 75, married and single, living in major cities and rural areas.

Among the findings:

- Seven percent of respondents reported having multiple sex partners in the previous year; 10 percent of those with added AIDS risk factors had multiple partners.

Respondents considered at high risk included those with a high-risk primary partner, intravenous drug users, blood transfusion recipients and hemophiliacs.

- Among heterosexual adults with two or more sex partners in the last five years, 31 percent were at risk of contracting HIV. In some metropolitan areas, the risk figure was 41 percent for this group.

- Among those with multiple partners, only 17 percent used condoms all the time. Condom use was only 13 percent among those with high-risk sexual partners.

- People with multiple sexual partners were more likely to be male, non-Hispanic, unmarried, highly educated and young adults. The number of sexual partners for whites and African-Americans totaled essentially the same.

- Women and low-income people were most likely to have risky sexual partners; about 71 percent of those with such partners did not use condoms.

In the United States, AIDS is still most prevalent among homosexuals and intravenous drug users. But Joseph Catania, a University of California researcher and a study author, said, "It is just a matter of time before it will spread widely into the heterosexual community."

## UIC team finds, loses tree for potential AIDS drug

[ CHICAGO ] A promising treatment for AIDS may be lost because of the loss of a tree in the Malaysian rain forest. A team working for plant explorer D.D. Soejarto, of the University of Illinois at Chicago, discovered a tree that produced a compound that stopped the growth of one form of the AIDS virus in laboratory tests. However, when Soejarto returned to get more raw material, the tree, a kind of *Calophyllum lanigerum*, had been cut down. No neighboring trees of the same species yielded the identical compound, he said.

The first sample was taken from the tree in 1987, and its derivative, Calanolide A, tested by the National Cancer Institute, was highly effective against HIV-1. In low concentrations, it stopped HIV's effects on human immune-system cells without damaging the cells, researchers said.

Soejarto, who also is on the staff of the Field Museum of Natural History, heads the team of ethno-botanists, funded by NCI, that hunts for plants in Southeast Asia in hopes of using them to develop new medicines before the rain forests are destroyed.

## Physician sued in AIDS test dispute

[ CHICAGO ] A physician at Bethany Hospital has been sued for allegedly administering an AIDS test without patient consent, then telling the patient's roommate the test results were positive.

The suit, filed in Cook County Circuit Court, alleges that by ordering the test earlier this year without first obtaining written consent, the physician violated the state's AIDS Confidentiality Act.

The suit seeks \$5,000 in damages, the maximum allowed under the law, from the doctor, who is an internist at the hospital, and from Evangelical Health Systems, which owns the facility.

## 32 health care workers contract HIV on the job

[ ATLANTA ] As of Sept. 30, on-the-job accidents had infected at least 32 health care workers in the United States, mostly lab technicians and nurses, with HIV, according to health officials at the U.S. Centers for Disease Control and Prevention. Twenty-seven of the 32 were infected by needles or scalpels that had been used on HIV-infected patients. Four were infected by touching the blood, mucous or damaged tissue of infected patients. One person had both kinds of exposure.

"This survey doesn't show us the risk of infection for health care workers. But

**THE ILLINOIS** Scientific Meeting, sponsored by the American College of Physicians and the Illinois Society of Internal Medicine, was held Oct. 30-31 in Peoria.

Above: Howard B. Shapiro, Ph.D., (left), ACP's director of public policy, discusses access to health care with Rep. Bob Michel (R-Illinois), minority leader of the U.S. House of Representatives.

Below: ISMS Secretary-Treasurer David B. Littman, M.D., gives a presentation on physicians and geriatric home care.



DUANE ZEHR

it helps us identify the circumstances of occupational transmission," said Dr. Carol Ciesielski, a CDC epidemiologist. "When we learn where people are becoming exposed, we can issue guidelines to prevent further occurrences."

## Evaluation of federal flu shot program begins

[ SPRINGFIELD ] Illinois seniors on Medicare Part B who received free flu shots the last two years as part of a federal pilot project are urged to get the shot this year even if they have to pay for it.

"This was a two-year trial, and everyone was told it was an experimental program," said Illinois Department of Public Health spokesperson Tom Schafer.

"Persons over 65 years of age or those with chronic illnesses should make arrangements with their own physician or their local public health department to be vaccinated again this year."

Thirty-four Illinois counties participated in the demonstration project, funded by the U.S. Centers for Disease Control and Prevention and the U.S. Health Care Financing Administration, to study the cost-effectiveness of providing free flu shots as a preventive measure. If the results show providing the free shots was cost-effective among Medicare Part B patients – and many physicians think it will – the government could recommend free vaccinations every year. But during the coming 12-month evaluation period, there is no funding for the shots.

About 2.5 million people nationwide participated in the program over four years. Last year, the second year Illinois participated in the study, about 95,000 Illinois seniors received the free shot. There is some concern that people who received the free shots the last two years might not be immunized this year if they have to pay for it.

Most local public health departments provide free vaccinations, but the policies vary from locale to locale, said Schafer. Some local public health departments provide the shot only to people over 65, while others provide it to anyone requesting it. Still others charge a nominal fee or request a donation. Nursing home patients on public aid receive the vaccination free, however. "The department contacted the public health departments in the test counties and warned them they would have increased demand this year," said Schafer.

## PHYSICIAN FACTS

### Illinois teens deaf to STD, HIV risks

• About one-fifth of high school freshmen surveyed in 1991 did not know that abstaining from intercourse, using condoms and not taking illegal drugs with a needle reduce the chances of HIV infection.

• In a 1989 survey of minority teens, more than half believed HIV could be transmitted by mosquitoes or other insects.

• In 1991, 40% of high school freshmen did not know HIV-infected people can spread the virus even though they are not sick with AIDS.

• In 1991, there were 10,116 new cases of gonorrhea and 596 new cases of syphilis reported among Illinoisans aged 10 to 19.

Source: Illinois Department of Public Health, Oct. 1992.

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# Deere & Co. poised to open health center

**DEERE HEALTH CENTER:** With the John Deere Family Health Center ready to open its doors the first week of January, Quad Cities physicians are faced with losing patients. By Tamara Strom

[ MOLINE ] Apprehension. Concern. Anger. Satisfaction. Resignation. All are emotions expressed by Quad Cities physicians about the new John Deere Family Health Center set to open the first of the year.

"Family practitioners in the Quad Cities are quite concerned that John Deere is replacing our function with doctors who are employed directly by the company," said James A. Bull, M.D., a Silvis family physician and past president of the Rock Island County Medical Society. "Many see it as a major intrusion on our ability to practice medicine in our community. Every patient they see [at the health center] is a patient a doctor in the community has lost."

Deere & Co. is offering the Family Healthplan option — which offers complete health care at no cost to all of its 35,000 employees, retirees and dependents — but will accept only 5,000 patients for its initial open enrollment period. However, those are 5,000 patients who previously received care from physicians in Moline, Rock Island, Silvis and other communities in the area.

Hurt most by the imminent clinic opening will be family physicians. Many are concerned about the prospect of losing longtime patients to the health center. Those Deere employees choosing the Family Health Center option for their insurance coverage will have to stop seeing their family doctors and switch to Deere-employed clinic physicians, or pay deductibles and copayments, some for the first time. The clinic coverage features 100-percent reimbursement for health care, with Deere family physicians acting as gatekeepers. Specialty care will be delivered on a referral basis by 77 area physicians selected by Deere. While the company offers its employees other insurance choices, Deere has strongly marketed the family health center, stressing that it is based on a model designed by the Mayo Clinic.

Dr. Bull said several of his patients have told him they will remain with his practice regardless of the copays and deductibles they will incur, but he is not sure how many patients he will lose to the health center. "Most of the patients I've heard from so far are patients who are choosing to stay," he said.

According to Deere officials, the company has already received "several thousand application enrollment forms." The 5,000 initial family health center enrollees will be accepted on a first-come, first-served basis depending on when their applications are received. "We will open the enrollment beyond 5,000 as soon as we can assimilate the first 5,000," Gordon Tjelmeland, Deere communication services manager, told *Illinois Medicine*. "Then we'll start a waiting list. As of [Nov. 13] the response has been very good."

But concern that the clinic will eat into their patient bases isn't all that worries Quad Cities physicians. They question what impact the loss of insured Deere patients will have on private physicians who provide care to indigent patients in the community. Several

physicians claim that Deere is just "skimming the cream off the top" and that the company has ignored the issue of indigent care in the Quad Cities. Some wonder how the community will offset the high cost of indigent care.

"Deere will be moving patients away from the private physicians, leaving those patients who can't afford to pay

for the private doctors in the community, since Deere won't be seeing any of them," Dr. Bull noted.

And while Deere has not explained if, or how, it will contribute to caring for uninsured and underinsured Quad Cities patients, discussions to that effect are under way, Tjelmeland said. "We've had numerous discussions with those health

care providers in the community, and we will be making a commitment to be a part of the community and to work with the indigent," he said.

Illinois State Medical Society Fourth District Trustee Richard P. Snodgrass, M.D., views Deere's entrée into health care delivery as a vivid illustration of things to come. "Corporate America and industry have burgeoning health care costs, and they will do everything they can to diminish those costs and remain competitive in the global marketplace," said Dr. Snodgrass, a Moline cardiologist selected for the Family Health

(Continued on page 17)

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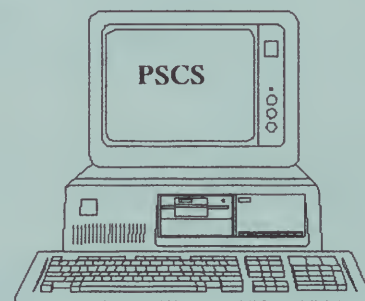
# REPORT

## FOR *Illinois Physicians*

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For more information on "PSCS" and what it can do for you, please refer to the Blue Cross Blue Shield Report for Illinois Physicians in the January 17, 1992 edition of *Illinois Medicine*.

(This report is published as a service to the physicians of Illinois)

12/04/92



## Tobacco bills on hold until 1993; tougher minimum-age laws sought

**SMOKING LEGISLATION ROUNDUP:** Illinois smoking and tobacco legislation fares poorly in 1992.

By Anna Brown

[ SPRINGFIELD ] As newly elected Illinois legislators begin to think about the upcoming year, bills seeking to curb smoking and tobacco use could well be on their agendas. However, if such legislation's failure to advance in 1992 is any indication, tobacco bill sponsors may still be out in the cold this spring.

Fifteen bills introduced in the House and Senate in 1992 failed to move

beyond third reading, with most being reassigned to committee. In the House, several bills focused on tobacco advertising, seeking to ban billboards featuring tobacco or alcoholic beverages in certain areas, such as near schools and churches. Others sought to amend the Illinois Clean Indoor Air Act by creating barriers to minimize the intrusion of smoke into nonsmoking areas and to guarantee

a smoke-free workplace. H.B. 1175, sponsored by Rep. William Shaw (D-Chicago), would create the Tobacco Sale Restriction Act, prohibiting the sale of any tobacco or tobacco product on state property.

In the Senate, three tobacco-related bills were reassigned to committee. S.B. 0004, sponsored by Sen. Earlean Collins (D-Chicago), would restrict tobacco and

alcohol outdoor advertising near schools. Creating the Alcohol and Tobacco Advertising Control Act, the bill would also require health warnings on outdoor tobacco and alcohol advertising.

The second bill, S.B. 823, sponsored by Sen. John Daley (D-Chicago) and Sen. Miguel Del Valle (D-Chicago), would repeal the Sale of Tobacco to Minors Act and the Smokeless Tobacco Limitation Act by creating the Tobacco Control Act, prohibiting the sale or distribution of tobacco products or accessories to minors. In addition, the bill would ban the sale of tobacco products and accessories in certain locations.

The third bill, S.B. 1203, sponsored by Sen. William F. Mahar (R-Homewood), would create the Airport Clean Indoor Air Act, prohibiting smoking in airports located in cities that have populations of more than 1 million and more than 150,000 flights per year.

**ON THE NATIONAL LEVEL**, an amendment to the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act, passed in June by the U.S. Senate and awaiting passage in the U.S. House of Representatives, would strengthen previously existing laws banning the sale of tobacco products to minors.

The Synar Amendment, named for sponsor Rep. Mike Synar (D-Okla.), calls for states to enact and enforce laws prohibiting the sale or distribution of tobacco products to those under age 18. The enactment of a minimum-age law would affect only a few states that either do not have a minimum-age law or set a minimum age lower than 18. The enforcement requirement will affect all states, none of which adequately enforce existing minimum age laws, according to the American Cancer Society.

The Synar Amendment could virtually assure enforcement of minimum age laws by denying block grant funds to states that do not comply.

The American Cancer Society hopes to see future legislation enacted on both the federal and state levels to increase excise taxes, regulate tobacco advertising in public places and further ban cigarette vending machines.

**A CITY ORDINANCE** enacted Oct. 27 by the village of Carol Stream will further restrict access of cigarettes and tobacco products to minors. Businesses selling tobacco products must pay a \$100 license fee, and employees under age 18 will be prohibited from selling tobacco products. The ordinance will take effect Jan. 1, 1993.

If business owners are found in violation of the ordinance, the village president can suspend or revoke the tobacco license and impose a fine of between \$50 and \$500, said Lynn Progar, Carol Stream deputy clerk. "Owners are responsible for their agents and employees, and if their license is revoked they can't get another for six months," she said.

Progar said that although no enforcement policy has yet been developed, "sting operations will occur probably no less than twice a year."

Because of the ordinance, Progar said the village has heard of several businesses — including one gas station — that have stopped selling tobacco products. She said they were told that under the ordi-

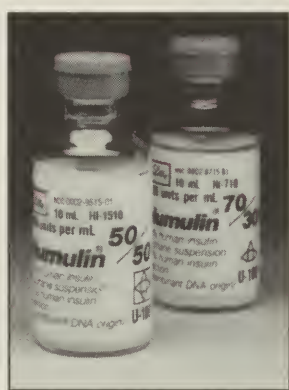
(Continued on page 17)



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# ISMS residency seminar focuses on candidate evaluation

**RESIDENCY:** Directors move beyond the basics of licensure.  
By Janice Rosenberg

[ CHICAGO ] Following the theme "Maximizing Residency Quality Licensing and Evaluation," this year's annual Illinois State Medical Society seminar for residency program directors moved beyond a basic discussion of licensure procedures to focus on the residency candidates themselves. Although past meetings centered on the nitty-gritty details of completing license applications, gathering documents and sending licenses on time, this year's speakers and attendees concentrated on evaluating residency candidates.

Factors affecting the Nov. 6 meeting agenda were last year's meeting evaluations and a recent survey of residency program directors. "The residency program directors feel the licensing process has become easier and more efficient, so now there are other things to work on," said Arvind K. Goyal, M.D., chairman of the Medical Licensing Board and president of ISMS. "The clinical skills determination needs to be made more objective; candidates need direct access to the department staff while their applications are being processed; and we need to look at the possibility of some type of pre-approval mechanism to help those kinds of applicants who historically take longer to get their licenses."

As in previous years, the meeting brought together residency program directors, representatives of the Illinois Department of Professional Regulation and members of the MLB. An analysis of the 1992 ISMS Licensure Tracking Survey showed that improved communication and increased cooperation among the three groups have resulted in smoother residency licensing periods.

The MLB is continuing to look at ways to further improve the licensure procedure. Using fax machines to transmit deficiency notices, interview notices and

some licenses saved time this year. The hot line for program directors was another time-saver, according to Dr. Goyal.

Although timely licensing remains vitally important, attendees appreciated the diversity of this year's meeting. Catherine A. Horan, Ph.D., administrator of institutional review for the Accreditation Council for Graduate Medical Education, spoke on internal evaluation requirements for residency programs. Amin N. Daghestani, M.D., discussed resident impairment and the ISMS Physician Assistance Program.

"If all this meeting did was give a reiteration of licensure, I probably wouldn't be here," said LaVerne Currie, M.D., internal medicine residency program director at Illinois Masonic Medical Center in Chicago. "There are other things in the program that interested me. In the future, I'd like to see coverage of resident recruitment ethics and sexual harassment."

Program directors also appreciated this year's focus on candidate evaluation. Donald Bosshart, Ed.D., chairman of the National Center for Evaluation of

Residency Programs, described the United States Medical Licensing Examination, a new three-part test that replaces both the Federation Licensing Examination and the National Board of Medical Examiners, Parts I, II and III.

Test results play only a small part in the overall evaluation process. "We're trying to assess the future competence of applicants," said Peter O. Fried, M.D., residency program director, emergency medicine, at Christ Hospital and Medical Center in Oak Lawn. "We need to judge their ability to master people skills and technical skills. We have to look into their knowledge, aptitudes and attitudes."

Evaluation of clinical skills becomes a special issue for residency applicants who have been out of medical school for

*"We need to judge [applicants'] ability to master people skills and technical skills. We have to look into their knowledge, aptitudes and attitudes."*

PETER O. FRIED, M.D.



WM. DANIELS/THE PHOTO PARTNERS

The theme of the 1992 ISMS seminar for residency program directors was "Maximizing Residency Quality Licensing and Evaluation." Panelists for the question-and-answer session at the Nov. 6 seminar included (from left) John M. Holland, M.D., and Lawrence L. Hirsch, M.D., members of the Medical Licensing Board; Pat Eubanks, manager of the medical unit for IDPR; and Kim Robinson, legal counsel for IDPR.

more than five years. The meeting gave the MLB a chance to hear feedback on this subject from residency program directors. "It's important for the program directors to know that the board members are one of them and that we do better when we know what's on their minds," Dr. Goyal said.

A lively exchange on how to measure clinical skills filled the seminar's afternoon segment. Gerald D. Suchomski,

M.D., program director of the Belleville family practice residency program, told *Illinois Medicine* that the meeting in general was valuable. "Today was very important to me because I was able to learn about some things that are on the horizon, like the USMLE and the impact of the Americans with Disabilities Act, on our interviewing and selection process. This has become a universally useful meeting."

## Resident Physicians Section links residents and organized medicine

By Janice Rosenberg

For the first time, the residency program directors' seminar was attended by a resident — Mark Bair, M.D., chairman of the Illinois State Medical Society Resident Physicians Section.

"Membership is very valuable for the residents and for the future of medicine," said Bair, a resident in emergency medicine at the University of Illinois. "Residents need to be involved in the state organization from the very beginning. We're the people who'll be taking over the top positions in the ISMS [in the future]. And because we'll be doing that in the environment that the people here are creating for us today, it's important for us to have a voice in the organization and know what's going on."

The ISMS-RPS offers support for residents on issues like loan payment deferments and residents' rights. "We just won a big battle with the Illinois state legislature," Dr. Bair said. "They were trying to mandate resident work hours, but we got them to agree to allow us to govern ourselves by following the resident review committee guidelines for the various residencies."

On Feb. 13, 1993, the section will hold a meeting called "Paving the Way to Practice." Discussions will focus on contracts and contract negotiation, professional liability issues, and the choice between a group or private practice. The meeting will be open to members and nonmembers.

## Legislative changes

(Continued from page 1)

reform. Although Republicans made inroads there too, increasing their presence by five seats and denying Speaker Michael Madigan of Chicago his 72-vote veto-proof majority, Democrats still outnumber Republicans 67-51.

"We can expect to see many of the same health care issues that we have seen in past sessions — from proposals to radically reform the state's health care system to expanding the scope of practice of allied health practitioners — again surface in the new legislature," said Dr. Goyal. "But it is likely that action on any health reform proposals will depend on two fac-

tors — the recommendations of the governor's new health care task force and what happens on the federal level."

Illinois lawmakers are expected to wait for the recommendations of Gov. Jim Edgar's new 36-member health care access task force before tackling any health care reform proposal. In announcing the task force Nov. 5, Edgar named ISMS Executive Vice President Alexander R. Lerner a member of the group and set a Feb. 1, 1993, deadline for the group's recommendations.

Formation of the task force was prompted by the July legislative compromise reauthorizing the state's Medicaid hospital assessment program. The program is expected to produce \$735 mil-

lion in federal funds for the coming fiscal year, but hospital and long-term care officials were adamant that the solution be temporary. Likewise, many legislators voted for the measure reluctantly, and several candidates from both parties interviewed by *Illinois Medicine* during its pre-election coverage specifically mentioned the need to find alternative funding for the state's indigent care.

Meanwhile, President-elect Bill Clinton has vowed that legislative action on health care reform is one of his key priorities for his administration's "honeymoon" during its first 100 days, and it is likely that Illinois' posture will be affected by any forthcoming federal initiative. One of the Clinton transition team's pri-

mary tasks is producing a timetable for drafting and introducing this and other legislation.

It is difficult to predict what tort reform may occur in the new session, according to legislature observers. The shift in the legislative balance of power, however, makes it possible that this and other issues (such as workers' compensation reform) could end up on the bargaining table during the traditional negotiations that characterize the final days of legislative action.

Tamara Strom contributed to this article.



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## EDITORIAL

# Who ya gonna call?

Silly season is over – the results are in and whether or not we agree with the rest of the electorate, we seem to have elected ourselves a new president, a new senator and several dozen new faces in Springfield.

There is one more vote you could cast – your vote for organized medicine. You vote by writing out a check for your ISMS membership and including a generous contribution for IMPAC. For 1993, this may be the most important vote you cast.

Because who are you going to call during the coming year for help, assistance, advice, leadership and advocacy on the issues that matter most to medicine?

Those issues are going to grow in significance over the year: We can expect universal health to surface again. Mandatory assignment is sure to be mentioned. Topics like prejudgment interest and attacks on the certificate of merit are bound to arise.

In addition, health care reform, a subject whose time has come, may be debated and shaped in Washington but decisions about implementation will be made in Illinois, no matter what format the federal plan finally takes.

Examples abound as a result of the recent election. President-elect Clinton, who initially supported a “pay-or-play” solution to health care reform, is now said to be considering “managed compe-

tion,” whatever that may be.

Illinois’ new senator has in this publication stated her support for a single-payer, tax-funded, universal health system that would be extremely unhealthy for Illinois.

And some of the new faces in the General Assembly told *Illinois Medicine* before the election that they hadn’t yet made up their minds on several issues important to medicine.

We have to be ready, ready to stand up for and stand fast for our patients, our profession and ourselves.

Again – who are you going to call to help you? The logical choice, the choice with experience in advocacy, is your state medical society. But we can’t be there for you if you aren’t doing your part by joining up, by speaking out, by participating in every way the Society needs you to.

What happens over the next year in terms of health care reform both nationally and in Illinois will probably affect the practice of medicine for several decades. You need to be a part of that process of reform and you need a strong, experienced partner at your side. That partner is the medical society.

Your 1993 dues assure that you have the advocate you need when reform hits the fan – and when you think about it, who else could you rely on?

## PRESIDENT'S LETTER

# Bending early is smarter than breaking later

By Arvind K. Goyal, M.D.



*“What could have been cured, had the cancer been detected a year or two earlier, was now a hopeless situation.”*

“I feel run down all the time, like I’ve no ambition, no pep at all,” Bob started to tell me as I was trying to “wake up” myself. He was my first appointment that Saturday morning. He went on, “Could it be because I’ve been working kind of hard lately, doing construction around the house, lifting wood and moving dirt?” “You’ve always worked in construction, haven’t you?” I asked, admiring my memory. “But this is different. It’s my own house, doc,” Bob clarified.

Bob then proceeded to detail other aspects of his history. I had not seen him in two years, but he seemed to have aged quite a bit more than that. At 56 he appeared at least 10 years older. He wouldn’t let me check his prostate. It was “too private” he said. All the talk about early detection didn’t matter. His examination was otherwise unremarkable. Appropriate testing ruled out many conditions, including diabetes. His heart was in good shape. The diagnosis centered around his excessive drinking, long work hours and some new stresses in his marriage. We talked more over the weeks that followed. His wife wouldn’t come with him for counseling or go anywhere else for that matter.

And then one day he surprised me. He met me in the examining room with his wife. “I have it all figured out for you,” he said as he introduced Rosie, “my best half.”

“You’ve got to give her a complete physical. She hasn’t seen any doctor since our baby – and he’s 22 now. I’ll feel good once you tell me she’s OK,” Bob went on. “And don’t forget to tell her to quit drinking, too.”

I had never met Rosie in the decade I had been her husband’s doctor. She admitted to drinking regularly, especially when working in the kitchen, and that she did often. She agreed to quit if I were to so advise. “No use seeing a doctor if you don’t follow what he tells you,” she said. Rosie got a C on her exam and didn’t pass the tests. Cervical cancer showed clearly on her Pap smear. They both seemed to handle the news as well as could be expected. Consultations followed. Surgery revealed cancer had spread to some lymph nodes. Radiation therapy

followed. Less than a week after her last radiation treatment her husband called. First he said it wasn’t an emergency, then, apparently looking at her, he changed his mind. My medical assistant decided to interrupt me to get me on the phone right away. “She can’t keep anything down today, and her stomach is hurting worse,” her husband told me. “Those pain pills you gave her help only for a little bit.”

She looked pale, sick and dehydrated – almost the color of death – when I saw her a short while later. Her color improved after a few days of treatment in the hospital with all those tubes, IVs and needles, but the abdominal swelling and distention never went away. Exploratory surgery confirmed what the CT scan had suspected. The uterus and cervix were better but the patient was dying. Diffuse cancer had invaded her abdomen. The surgeon had no choice; get out quickly. Chemotherapy was planned.

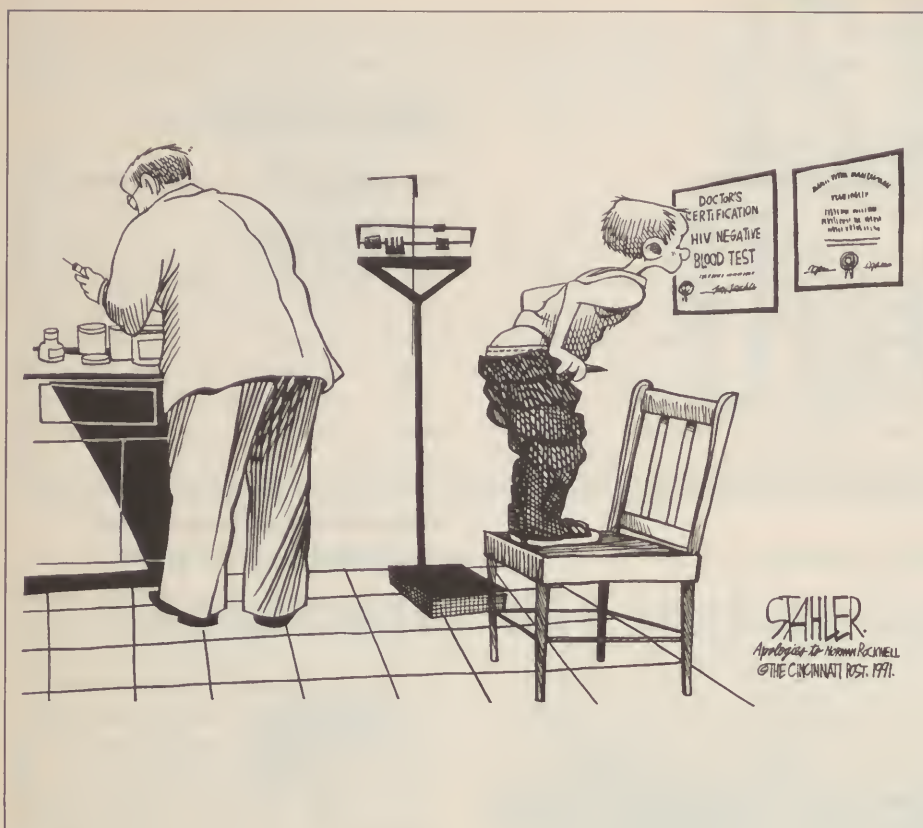
I vividly remember our three-way conversation the next morning, the patient in intensive care, her husband and her doctor standing at her bedside. We rehashed everything.

“What I don’t understand,” her husband said, “is how quickly she’s gone downhill since I brought her to you two months ago.” I was speechless. That comment was not expected. The patient helped me: “I guess we came to you too late.” We then talked about the virtues of early detection. What could have been cured, had the cancer been detected a year or two earlier, had developed into an absolutely hopeless situation. We discussed advance directives. We’ll keep her comfortable all the way to the end, we agreed.

Everything wasn’t wasted, though. Bob showed up in my office the next day, wanting his prostate checked. “I didn’t think I’d ever want to bend, but after seeing Rosie, I guess I’d better.” I did the honors, and also ordered a prostate-specific antigen blood test.

*This column is a reflection by Dr. Goyal. Names and identifying details have been changed to protect the patients’ privacy.*





## LETTERS

## Disability and discrimination

I read an article in *Illinois Medicine* regarding the employment provisions of the Americans With Disabilities Act. The Illinois State Dental Society has been most interested in this new act as it relates to dentistry.

In that respect, the article appeared quite accurate to me overall. However, I fear the article may have misled some physicians in stating, "Physician practices with fewer than 15 employees need not comply with Title I provisions." Although this is true for the provision under the ADA, it is our understanding that the related Illinois state law, the Illinois Human Rights Act, prohibits all employers of at least one employee from discrimination in employment matters.

I suggest you consult with ISMS legal counsel and consider clarifying this point for Illinois physicians who may believe that because they have fewer than 15 employees, they need not comply with ADA's Title I provision.

I enjoy reading each issue of *Illinois Medicine*. Keep up the good work.

— Robert A. Rechner  
Executive Director  
Illinois State Dental Society  
Springfield

*Editor's note: The point regarding state law is well-taken. According to ISMS counsel, employers with at least one employee must comply with the Illinois Human Rights Act and refrain from discrimination in employment matters.*

## GUEST EDITORIAL

## America set apart on health care

BY CONRAD MEIER

Our health care system is constantly criticized for being the most expensive in the world. And many argue that we do not get a fair return for the massive amount of money we spend.

Most often, however, those who push health care reform neglect to identify the driving forces behind medical spending in the United States and the way our society has created the "norms" that drive up spending.

Consider, please, some intrinsic differences that may prove informative: The U.S. homicide rate among males is 12 times that of what was West Germany and five times that of Canada. The violent-crime rate is high as well. Japan, with about 120 million people, has fewer than 2,000 homicides, robberies and rapes in an average year. The United States, with only twice the population, had 629,000 such crimes in 1987. That's about a 300-fold difference! Crime is related to health care in that victims of violent crimes are most often treated in emergency rooms, which is the most expensive place to get health care.

In the 1980s, the United States had three times as many cases of AIDS as did Canada. The teenage pregnancy rate in our country is 2.5 times that of Great Britain and Canada. Teenage mothers are less likely to receive prenatal care and are prone to giving birth prematurely. One extremely premature baby will cost about \$158,000 a year to save. The United States spends \$2.6 billion a year on neonatal intensive care.

The United States is committed to doing everything possible to save these early births. Not so in other countries. In Sweden, babies with a low survival rate have treatment withheld. The British often withdraw treatment if the infant is likely to die or become brain-damaged.

On average, a U.S. hospital will deliver 104 cocaine-addicted babies each year and about 375,000 "drug-exposed"

infants. One best estimate puts the cost of treatment at \$63,000 per baby for the first five years. That's around \$25 billion.

The "elder factor" is higher in the United States than in Canada. If Canada had the same percentage of elderly as does the United States, Canadian health care spending would be 5.3 percent higher than is reported today. On average, the cost of care for a person over age 65 is 3.9 percent higher than for a younger person. Estimates from another study indicate that spending on health care in the last year of life was \$54 billion in 1990. No other country extends such quality health care for its elder generation, regardless of willingness or ability to pay for treatment.

Our population is twice the size of the second largest industrialized nation, Japan. However, we are spread over a continent, making our population density lower than most other countries. Germany's density is 8.2 times that of ours, while Japan's is 12.5 times higher. Because health services need to be provided near the centers of population or the patients, the United States is forced to spread out and use more expensive high-tech equipment and more labor per capita than most countries.

Of the countries we are often compared to, only Canada and Australia have lower population densities. Both these countries are distinguished by high population concentrations in small areas.

Well-meaning legislators have passed more than 1,000 laws mandating specific medical services. The cost is passed on to the health insurance policyholder, whether such coverage is desired or needed. As much as \$60 billion a year is reflected in higher insurance premiums. Some mandates are absurd and serve a limited special-interest group: hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont, in vitro fertilization in Illinois and sperm bank deposits in Massachusetts.

John Goodman of the National Center for Policy Analysis and economist Gerald Musgrave estimate as many as 8.5 million people are priced out of affordable health insurance by these mandates. It has been my experience that the average uninsured would be much happier with a basic package of medical benefits that is affordable, than a broad-based policy that covers everything but is available to only a few.

*Imitating systems that appear to work in other countries is a shortsighted approach to fixing what has been identified as unacceptable within our own system.*

Since 1965 and with the passage of Medicare law, government involvement with health care has grown to the point where it will spend more than \$400 billion, or half of all health care dollars in the United States, for 1992. However, Medicare and Medicaid payments continue to fall short of actual costs for care received. The relationship of government involvement to health care spending is that underfunding these programs has forced providers of health care to shift the uncompensated burden of public programs to the privately insured. This shift is estimated to have increased group and individual health insurance premium costs by a full 30 percent.

The lesson here is that any government capable of giving something to citizens is

also capable of taking from citizens.

Much has been said about malpractice reform. Recent studies indicate the program may be even worse than estimated. Our litigious attitude costs us dearly: The American Medical Association estimates that \$5.7 billion was spent on malpractice insurance premiums in 1985. However, and worse, the \$3.7 billion paid by physicians and \$2 billion paid by hospitals pales in comparison to the \$11.7 billion spent on the "defensive medicine" created by the threat of a lawsuit. Defensive medicine consists of all the prescribed diagnostic tests that inflate the cost of health care, look great in court, but do not benefit the patient in any manner.

Those who would reform our health care system must take a deeper look into the health care statistics that shape and define what is uniquely ours. Imitating systems that appear to work in other countries is a shortsighted approach to fixing what has been identified as unacceptable within our own system.

The United States has created a society that expects more from its medical system. We subject ourselves to lifestyle choices that add billions in health care expenses and that are clearly not in our best interests. The ultimate irony is we then bemoan what it costs to restore our health. We ignore the reality of having arrived at a time when we can no longer afford the advanced medical technology we have invented.

Any reform to our system must be as unique as the society we have created for ourselves. We are inherently different from Canada, Great Britain, Japan and all the other countries to which we are incorrectly and routinely compared.

Conrad Meier, Columbia, Mo., is a health insurance consultant.

Reprinted as published by the St. Louis Post-Dispatch, Sept. 8, 1992.



The Illinois State Medical Society Board of Trustees met Nov. 14 at the ISMS Conference Complex in Chicago. The following are highlights of the board's actions:

#### ISMS to address health reform

Three ISMS agencies will work together to address ISMS proposals for, and physician and public education about, health care reform. The Third Party Payment Processes Committee is working now to devise a reform proposal. The Council on Public Relations and Membership Services has concentrated its

efforts on public education about ISMS' Ten Principles, and the Council on Economics has emphasized physician and public education on the factors contributing to health care costs. Since several House resolutions call for aggressive action, the board agreed that the issue was critical and could be appropriately and efficiently addressed by a three-agency subcommittee.

#### Board to seek specialty input

Illinois specialty society leaders who are ISMS members will be invited to board meetings to provide information and express concerns about issues in their

specialty society. Invitations to each board meeting will be issued to two specialty society leaders.

#### Board to review legislative strategy

ISMS will act swiftly to meet the challenges of dramatic changes in the legislative and executive branches of federal and state government by establishing a coherent, effective and redirected strategy to influence federal debate on health reform. The plan will include communicating with ISMS members, motivating them to participate in any public and legislator awareness campaigns about

ISMS-endorsed proposals for reform, and investigating the benefits of future alliances. The board will discuss the plan at its January 1993 meeting.

#### Drs. Johnson, Orlowski appointed

Eugene P. Johnson, M.D., of Casey, was appointed by the Illinois Department of Public Aid to chair the Illinois Department of Public Aid Drug Utilization Review Committee. Janis M. Orlowski, M.D., of Chicago, was appointed by ISMS to serve on the Illinois Comprehensive Health Insurance Plan Board of Directors.

#### ISMS-ISBA interprofessional conference on impairment

Citing the excellence of the ISMS Physician Assistance Committee and program, the Illinois State Bar Association has asked ISMS to participate in an interprofessional conference on impaired professionals. Appointed to help plan the conference were James H. Andersen, M.D., of Oak Brook; Harold L. Jensen, M.D., of Frankfurt; and James C. Leonard, M.D., of Mahomet. The conference will be held in May 1993.

#### ISMS asks for AMA's help with 'medical necessity' denials

ISMS and the American Medical Association will try to obtain agreement from the U.S. Health Care Financing Administration to discontinue the practice of using the term "medical necessity" in denials addressed to the patient. ISMS told the AMA that use of the term indicates a qualified health care practitioner made a clinical judgment about the procedure or service performed, when in actuality the denial was judged on preset statistical parameters unrelated to the concept of "medical necessity."

#### ISMS to sponsor workshop for CME planners, site surveyors

Following a successful Oct. 2 multitrack program for CME planners and accreditation site surveyors, ISMS approved continuing its annual programming for the fall of 1993.

#### ISMS approves CME faculty disclosure form

ISMS adopted a disclosure policy for CME faculty to indicate any significant financial interest or other relationships with commercial supporters before serving as a presenter at a commercially supported ISMS CME program. The confidential information provided by the faculty member will be disclosed only after consultation with the faculty member or the corporate supporter. This policy parallels the requirement of the standards for commercial support of CME adopted by the Accreditation Council for Continuing Medical Education and ISMS.

#### ISMS to provide DNR amendments to IDPH

ISMS will ask the Illinois Department of Public Health to clarify rules governing licensure of intermediate care facilities for the developmentally disabled, to establish that a physician is not obligated to write a DNR or any other order for a patient. Rule clarifications also include standardizing definitions of "decisional capacity," according to the Illinois Health Care Surrogate Act. ■



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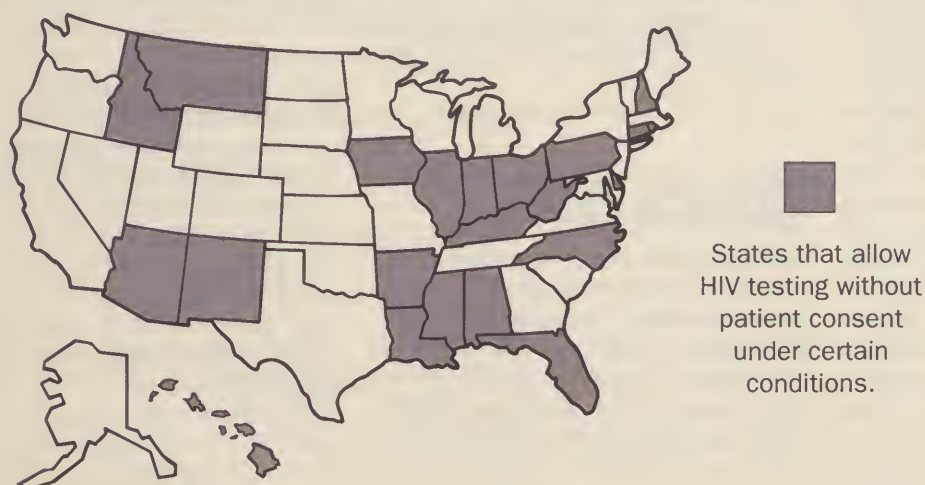
# EXCHANGE BOARD BRIEFS

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# ISMIE Update



## States with HIV testing laws



Source of data: Intergovernmental Health Policy Project, George Washington University, 10/92.

### GUEST EDITORIAL

## Liability risks in HIV care

BY LAWRENCE O. GOSTIN, J.D.

**H**ealth care providers are prohibited by law from discriminating against people with HIV infection or AIDS. Accordingly, providers – whether they be in primary, secondary or tertiary care – must treat people with HIV infection as they would treat non-HIV-infected people presenting with the same medical condition. This “duty to treat” is derived from disability law, notably the Americans with Disabilities Act.

Generally speaking, health care providers must use the level of knowledge, skill and care that would be used by any prudent and careful professional in his or her chosen specialty. The “standard of care” for treating HIV disease and AIDS is in a state of flux, unlike the standards for treating most other diseases. Failure to stay abreast of prevention measures and treatments for HIV disease and AIDS places health care providers at risk of liability if the patient is harmed. It is therefore imperative that providers remain up-to-date on the most current standards of practice for treating people with HIV disease and AIDS.

Liability may ensue if providers unreasonably fail to diagnose HIV infection or its symptoms, fail to appropriately treat (or refer for treatment) all significant physical and psychological conditions of HIV disease and AIDS, fail to maintain patients’ confidences, or fail to protect patients and their partners from foreseeable harm.

**HEALTH CARE PROVIDERS** must balance patient rights with professional duties. Patients have the right to consent to medical treatment. Most states have statutes that specifically require informed consent for HIV testing. It is important for providers to know exact statutory provisions in their state, because the statute may allow testing without consent in some situations (for example, following a needle stick injury to a health care worker). The U.S. Centers for Disease Control and Prevention recommends providers comply fully with state laws in obtaining informed consent for HIV testing.

Informed consent need not be viewed as a burdensome legal requirement, but as a good professional and ethical practice.

The CDC recommends that pretest counseling go hand-in-hand with informed consent. The CDC also recommends posttest counseling, which includes providing information about high-risk behaviors for HIV infection. In order to protect the public health, all patients who do test HIV-positive should be professionally counseled.

Health care professionals must be capable of diagnosing HIV infection, HIV disease and AIDS. Assume a patient presents with lymphadenopathy, unexplained weight loss or a chronic vaginal infection. If the physician fails to take an adequate history, perform a thorough physical examination, and offer the appropriate laboratory test – including an HIV test – he or she may well be at risk of liability.

Failure to diagnose HIV infection may result in foreseeable harm to the patient, such as not treating an opportunistic infection or prescribing inappropriate treatment for the patient’s symptoms.

An incorrect diagnosis would also mean, most likely, that

(Continued on page 11)

## Providers should consider AIDS patients’ rights

**LIABILITY:** As more AIDS and HIV-positive patients seek treatment, potential physician liability may increase. By Anna Brown

[ CHICAGO ] Physicians who treat AIDS patients need not fear malpractice liability repercussions if they are conscientious about patient rights, some doctors say.

Physicians can now intervene early to improve not only the length of life, but quality of life as well, said Anthony H. Dekker, D.O., a Chicago family physician and former member of the Illinois Task Force on AIDS in Health Care. The extended life span and improved quality of life for AIDS and HIV-positive patients signal a change in their treatment over the past few years that could also increase their expectations and possibly physicians’ liability as well, according to Lawrence O. Gostin, an attorney with the American Society of Law and Medicine in Boston.

“Ethically, patients have the right not to be refused treatment based on the diagnosis of AIDS,” Dr. Dekker said. But when physicians agree to treat an HIV-positive patient, they assume several equally important responsibilities.

The biggest responsibility involves physician attitude, Dr. Dekker said. AIDS patients deserve the “same compassion, competence and availability of care” as other patients, he noted. Physicians must also be knowledgeable about the disease and should be “well-read and well-experienced.”

Another primary responsibility for physicians, one that is required by law, is following the guidelines for universal precautions established by the U.S. Occupational Safety and Health Administration. The guidelines – which require the use of protective equipment, including gloves, and sterilization procedures – protect not only physicians, but also staff

(Continued on page 11)

## Physician judgment and informed consent

According to Illinois’ AIDS Confidentiality Act, “no person may order an HIV test without first receiving the written informed consent of the subject of the test or the subject’s legally authorized representative” unless specified exceptions apply. Cases requiring physician judgment arise when a health care provider or health facility employee “is involved in an accidental direct skin or mucous membrane contact with the blood or bodily fluids of an individual which is of a nature that may transmit HIV.” However, if the test proves positive, the patient has the right to receive appropriate counseling.

Physician judgment is also required to determine whether HIV testing is “medically indicated to provide appropriate diagnosis and treatment,” as long as the physician has received the patient’s informed consent for medical treatment.

Other circumstances in which informed consent is not required for HIV testing include the testing of anatomical gifts; the provision of semen for artificial insemination provided prior to the Act’s effective date; and research testing of anonymous samples.



## EXCHANGE BOARD BRIEFS

*The Illinois State Medical Inter-Insurance Exchange met Nov. 13 at the ISMS Conference Complex in Chicago. The following are highlights of the board's actions:*

### Exchange Nominating Committee appointed

Jere E. Freidheim, M.D., of Chicago, will chair an Exchange committee to nominate physicians to serve on the Board of Governors beginning in April 1993. Other members of the nominating committee include Henri S. Havdala, M.D., of Chicago; Boyd E. McCracken, M.D., of Greenville; Robert M. Reardon, M.D., of Bloomington; and Irwin A. Smith, M.D., of Northbrook. Governors whose terms expire in 1993 include Peter A. Brusca, M.D., of Carol Stream; David W. Cromer, M.D., of Evanston; Lawrence L. Hirsch, M.D., of Northbrook; Raymond E. Hoffmann, M.D., of Rockford; Eugene P. Johnson, M.D., of Casey; David B. Littman, M.D., of Highland Park; and Walter W. Whisler, M.D., of Chicago.

Any Exchange policyholder may submit nominations for governor, and all can vote. The deadline for nominations

to be received is Feb. 4, 1993. New governors will begin serving at the organizational meeting of the Exchange Board of Governors April 21 in Oak Brook.

In keeping with its ongoing commitment to evaluate and improve policyholder service, the Nominating Committee will develop ways to evaluate qualifications of new and incumbent members of the Board of Governors.

### Exchange and PIAA compared

The Exchange's average indemnity at or in excess of \$100,000 is 22 percent greater than those of other physician-owned malpractice insurers nationwide. The Exchange's overall average indemnity is 46 percent higher than the overall average indemnity of the same physician-owned companies. The Exchange has established that working toward capping noneconomic awards in Illinois will be a priority in its continuing efforts to improve the malpractice climate in the state. With such a cap, excessive settlements and verdicts would be less likely. Physician-owned companies in states that have caps have lower average indemnity, at or in excess of \$100,000.

### Exchange reaffirms medical records guideline

Alteration of medical records will continue to be grounds for nonrenewal. The Exchange recognizes that errors in medical records can be corrected appropriately, but emphasizes that altering medical records in response to a potential or existing lawsuit reduces the physician's credibility in court and can result in a punitive jury and excess verdict. When the medical record has been altered, the Exchange usually has to settle, rather than risk an adverse decision at trial. All Exchange cases are reviewed by physicians, and decisions about settlement, defense and continued insurability are made by Exchange physicians.

### Policyholders warned of Data Bank Response Association

The Exchange Board heard a report that the U.S. Health Resources and Services Administration Bureau of Health Professions has advised the National Practitioner Data Bank that an entity promoting itself to physicians as the National Practitioner Data Bank Response Association "appears to be a

gimmick to identify high-risk physicians to sell them high-risk insurance." Physicians solicited by this organization should be warned that services and benefits offered may not be forthcoming, according to the American Medical Association.

### Exchange offers early risk management support to physicians

As a result of a new Exchange activity, policyholders identified by reviewing physicians as needing risk management support now receive such support earlier in their careers. The Physician Review Committee, which reviews claims and suits against Exchange policyholders and recommends settlement or defense, can now also recommend risk management intervention. The risk management support may take the form of a self-study or seminar course or a practice audit by an Exchange physician, usually a member of the same specialty. Such referrals from PRC to the Exchange's Risk Management Committee should be viewed as an educational and supportive opportunity for the physician to head off future claims or suits. ■

## Tailored Health Benefits



Photo: 1927 Yale Football Team



## Liability risks in HIV care

(Continued from page 9)

patients would not receive counseling on avoiding high-risk behaviors. Thus, if a patient is misdiagnosed, and is indeed HIV-positive, and that patient passes the virus to a partner, the physician may be liable for harm to the partner as well.

**EARLY ON IN THE AIDS** epidemic, patients may have been reluctant to file claims against health care providers for inappropriate care. It was widely, perhaps inaccurately, assumed that rigorous treatment could do little to improve patients' lives.

Today, the value of AIDS treatment is much clearer. AIDS is beginning to be seen as a manageable, chronic disease. Treatment decisions at various stages of the illness can have a significant effect on the length and quality of patients' lives.

Despite the known value of early intervention, a contradiction has emerged in the treatment of HIV-infected patients. Many health care providers behave as if HIV infection and AIDS are rare diseases that require specialized facilities to treat. They claim a lack of expertise in treating HIV-infected people and routinely refer patients to major hospitals in urban areas. The epidemiologic facts, however, present HIV infection as a disease with wide prevalence and an increasing geographic and demographic distribution—a disease for which there are many sources of treatment and treatment information. The fact that some 1.5 mil-

lion or more people in the United States are infected with HIV means that providers, including primary care physicians, need to have adequate knowledge and skills to treat these individuals. HIV-infected patients should be referred to specialists only when it is clearly required.

**FOR SOME AIDS-RELATED** conditions there are few, if any, established treatments, and the only hope for patients may reside in innovative, often unapproved treatments, such as in the "off-label" use of a drug or as part of a clinical trial. Courts are likely to look favorably upon those physicians who use unestablished treatments when there is no proven alternative, provided there is some basis in medical literature or practice for the

treatment. The duty to inform patients of their most promising chance for improvement may not be far beyond the current legal horizon.

**THE GUIDELINES FOR INFECTION** control in hospitals, private practice offices and other health care facilities are established by the CDC and various health agencies, like the U.S. Occupational Safety and Health Administration.

Recently, OSHA adopted legally binding regulations that require the use of gloves and other protective equipment and sterilization procedures in health care settings. If a patient or a health care professional contracts HIV or any infectious disease in a health care setting where guidelines were not being adhered to, the physician or hospital risks sub-

stantial liability.

The law is seldom clear, simple or easy for health care providers to follow. They must be diligent and conscientious in complying with the law and with industry guidelines. Physicians should be well-educated in diagnosing and treating HIV disease and AIDS, well-informed about the CDC and other ethical, professional guidelines, and well-versed in counseling HIV-infected patients.

*Reprinted from PAACNOTES (Vol. 4, No. 6), the monthly newsjournal of the Physicians Association for AIDS Care, Chicago.*

*Lawrence O. Gostin, J.D., is an attorney with the American Society of Law and Medicine in Boston.*

## AIDS patients' rights

(Continued from page 9)

and patients, from infection, Dr. Dekker said.

"Physicians must also be very sensitive to the fact that AIDS is a multidisciplinary problem," he continued. "A wide variety of professionals work in tandem with physicians to treat all aspects of the disease. These professionals provide social, psychiatric, legal, pastoral and family services.

"Physicians *have* to network," Dr. Dekker continued. "Doctors make good doctors but lousy social workers. They have not always been good team players in the past."

**OTHER LIABILITY ISSUES** physicians need to be aware of include testing procedures and patient education, Dr. Dekker said.

"Each person has a right to informed consent [for AIDS testing]," he said, emphasizing the importance of pretest and posttest counseling. "Patients have the right to review and discuss all consequences of taking or not taking the test, as well as the right to refuse or accept the test.

"AIDS is a preventable disorder," Dr. Dekker said. "Every physician must play a role in patient education, explaining risk behaviors and making appropriate recommendations. The best approach is continued emphasis on prevention."

Dr. Dekker believes there are still some

unresolved issues, such as partner notification and emotional disorders in patients who refuse psychiatric care. Also, to what extent should a physician become involved when an infected patient continues high-risk behavior?

"Physicians have the responsibility to advise patients to do the most appropriate thing and to help them make that decision," Dr. Dekker advised. "However, doctors can't make the decisions for patients.

"Every physician in Illinois should assume some responsibility in addressing the AIDS crisis," Dr. Dekker concluded. "No one should run away from the disorder." ■

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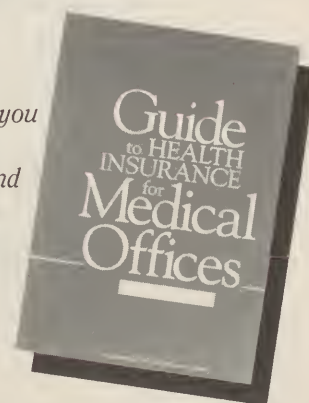
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ONE PHYSICIAN'S STRUGGLE WITH HIV

# Living on the other side of the stethoscope

*After being diagnosed as having AIDS, an Illinois physician gave up his practice and now faces life as a patient.*

BY TAMARA STROM

I got into my car, and I drove off. I could hardly see the road. I was just crying. It was everything I had worked for, and it was gone. Gone overnight. It was just so intense I can't describe it. It's just as though a guillotine has fallen, and all of a sudden you're all by yourself."

That day a few years ago still weighs heavy on the mind of Dr. Jonathon Bramen.\* It was the day he practiced medicine for the last time. He had to quit because he was too sick to continue. A successful Chicago physician struck down in the prime of his career — and his life — by the hand of fate, as he called it, suddenly he was faced with AIDS.

#### You've really done it

"I was not feeling well at all," Dr. Bramen said. "It was to the point that in between patients I would be taking a little nap at my desk. I'd close the office door and put my head on the desk. I just couldn't keep going. I was so abnormally tired that driving home from the hospital I literally fell asleep on the freeway and almost hit the median. This happened two times. I didn't know what was wrong. But I knew something wasn't right."

About 10 years earlier, during his residency, he had stuck himself with a needle while drawing blood. "The needle ... slipped right into my hand," Dr. Bramen said. "Within the incubation period I came down with hepatitis. That wasn't the only time I'd ever

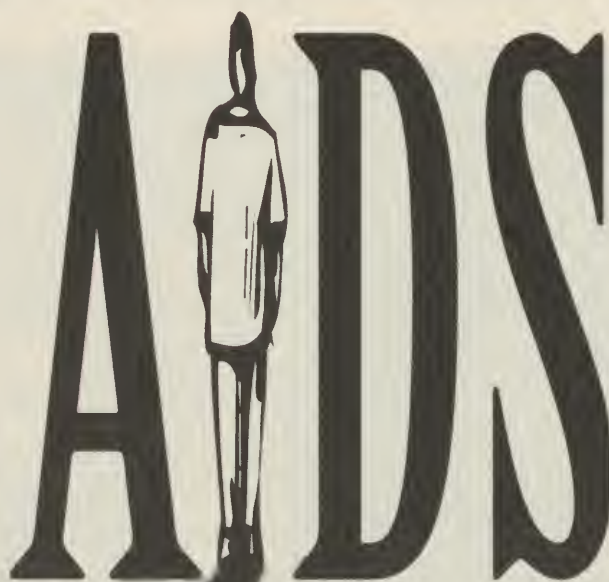
stuck myself, but it's the one I remember. It was definitely blood that I was dealing with. It wasn't just a clean syringe or an injection needle."

At the same time he contracted hepatitis, he also had a serious case of pharyngitis and enlarged lymph nodes. "Now, we're talking 10 years ago," he explained. "At that point we didn't even know that AIDS existed. It was just beginning to come out in the articles. When I was training, you didn't put on gloves for everything. There was blood all over the emergency rooms.

You'd be covered in blood. There was none of this protective gear. It was really macho to be in there in the blood and guts of it all.

"But I had an odd feeling when I stuck myself," he said. "I don't know what it was, it just came to me. 'You've really done it now.'"

In retrospect, this series of events seems to fit the





## ONE PHYSICIAN'S STRUGGLE WITH HIV

description of HIV seroconversion. "But of course at that time, I didn't even think of that," Dr. Bramen said, adding that in the early 1980s no test for detecting HIV infection existed. "I just went on. I recovered from the hepatitis, completed the last year of my residency and went on to practice."

**Over a cup of coffee**

"When I first found out, I didn't know what to do. What should I do first? I was in a group practice, so the first thing I had to do was tell my partner. I just couldn't figure out how I was going to approach this person."

"One day we were sitting [at the hospital] and writing in our charts, since we had made rounds at the same time," Dr. Bramen said. "I looked across the table and I said, 'I've got something I've got to tell you.' We both got a cup of coffee. I said, 'We can't talk about it here; we'd better go back in the office.' We sat down. I just simply came out with it. 'I've been tested, and I haven't been feeling well; this is what the results are.'"

"For both of us it ended up being a very emotional situation, to the point of tears," he recalled. "But it's a business, and because of my T-cell count being what it was, I didn't feel it would be in the best interest to continue practicing."

The stress of the practice also added to his decision. "I was putting in these long 12-hour days, and I just couldn't continue. I was exhausted. I thought it would be best that I dropped out. The comments from my partner were very supportive, and they still are. We had to look at the situation realistically to keep the practice going. We had to make plans."

Over the next three months, Dr. Bramen scaled back his patient load until all of his patients had been discharged. "I ended up leaving the practice," he explained. "One of the hardest things was to leave all the people that I worked with, and to really not have much of an excuse to leave a thriving practice at such a young age — other than that I was taking some time off, like a sabbatical, and that I hadn't really decided what I was going to do after that."

**T**he doctor is in more danger of being infected than the patients are. That's not just the party line; it's fact.

**A magic pill**

"The worst is the absolute loneliness," Dr. Bramen said of living with HIV and not being able to practice medicine. Although he has many supportive friends and a loving family committed to taking care of him if "things get rough," he has lost friends who have "disappeared into the woodwork. They don't want to become attached to you and watch you wither away."

He also misses the camaraderie he once had with other physicians. Dr. Bramen has not disclosed his HIV status to many people, other than close friends and family, in part because he fears a patient liability suit. "If there were some magic pill and all of a sudden you could get better, I'd be back there [practicing]. It was my life. I had spent about 14 years in medicine. I only got to practice for about 10. And that was it. And, yes, I miss it a lot. Just the interaction with other physicians. But with the legal profession the way it is right now, it's better to remain anonymous."

**'We don't have this problem here'**

As a patient with HIV, Dr. Bramen said he has suffered through some episodes of "nasty" treatment at the hands of physicians. As a doctor, he said he finds these experiences particularly painful.

During a trip home to another state to visit his parents, Dr. Bramen got an infection — not an AIDS-opportunistic infection, but an infection anyone could get, he

**B**ut I had an odd feeling when I stuck myself. I don't know what it was, it just came to me: "You've really done it now."

explained. "I went into the emergency room, and my dad went with me," he said. "I had a temperature of 102 and a developing abscess. I explained as I went through the front door that I was a physician and that I was HIV-positive. I wasn't hiding anything from anyone. I went into the exam room, and in walks a physician who says, 'Well, you know more about this than I do. We don't have this problem here.'"

Although the doctor examined Dr. Bramen, he didn't admit him to the hospital. Instead, he sent him home with pain medication.

"At this point I was so sick I didn't know what to do," Dr. Bramen said, adding that his parents' home was too far from Chicago for him to return to the care of his personal physician. "Well, I proceeded to get sicker and sicker overnight. I went back to the emergency room in the morning and demanded to see the doctor. His whole attitude was that I would be better off if I went back to Chicago. No one wanted to touch me."

By then extremely ill, Dr. Bramen sat helplessly as he lost his confidentiality in this rural hospital emergency room in his hometown. "Out in the middle of the emergency room ... [the physician] proceeded to sit at that telephone and called five doctors, four of whom refused to take care of me. He announced my name. He announced that I was a physician from Chicago and what my diagnosis was, i.e., HIV. This was all in public view. This is a small town; everyone knows everybody."

Finally, an oncologist agreed to treat Dr. Bramen, but he, too, had the "same fearful attitude." During the course of a two-week hospitalization, Dr. Bramen said he saw that physician only about five times. And each time the doctor came to see him, he sat on the other side of the room. "Luckily, I did get appropriate treatment, but not emotionally. I would be afraid to be in the same situation if it were a more severe infection. If it were an opportunistic infection, which it was not, I would have been in trouble."

**It happens**

As an inpatient in Chicago, Dr. Bramen said he has witnessed fellow physicians treating other AIDS patients poorly. On one occasion a physician entered the room to examine Dr. Bramen's hospital roommate. The first words uttered by the physician, Dr. Bramen said, were, "Why didn't tell us you were in the hospital? Have you got your insurance straightened out yet?"

"That really irked me," Dr. Bramen said, especially because he had consulted with this physician by phone when he was still practicing. "He didn't know there was a physician in the next bed," Dr. Bramen said. "It was

(Continued on page 14)



## Living on the other side of the stethoscope

(Continued from page 13)

this pompous attitude. A total lack of concern about the patient. He asked only one or two clinical questions and was out the door.

"And yet, we [physicians] just continue on in our day-to-day practice and think it's never going to happen to us," Dr. Bramen added. "Well, I'm proof. It happens."

### Some of the warmest, caring doctors

Although he says he is compelled to report negative stories about poor physi-

cian attitudes toward HIV-positive patients so "they don't get swept under the rug," he is quick to praise other physicians who provide superior care for these patients. "The doctors who are involved in the actual day-to-day care of HIV patients, as far as I have had experience, have been very, very caring physicians," he said. "They are probably some of the best physicians I've ever met. They're very warm. They listen to what you tell them and spend some time with you. They have an empathy."

He can call his own physician at any time with any problem. "And it's not just because I'm a doctor," Dr. Bramen said. "The other patients I've met who have gone to him all say the same thing."

While he says the quality of his physician's medical judgment is "excellent," Dr. Bramen noted that it is sometimes difficult to sit back and be the patient. "You have to let the physician make the decisions. You can't be treating yourself. And that's hard. It's very hard."

### I don't have time for that now

When he was first diagnosed, Dr. Bramen had a T-cell count of 240. Today it is 91. He is fighting a bout of cryptosporidium, a gastrointestinal infection that causes severe diarrhea. Between the spring and fall, his weight dropped from 159 to 127, but now daily 12-hour total parenteral nutrition IVs have bolstered him back up to 140 pounds.

Dr. Bramen still feels well most days. He is able to get out and exercise, and he takes long walks every day. He doesn't have to worry about keeping a roof over his head or paying his ever-mounting medical bills.

"I was very foresighted, I guess," he explained. "I got disability insurance. I'm very happy I did, and I would have to say to any physician who doesn't, 'For heaven's sake, get insurance. You never know what could happen to you.' It may not be [HIV], but no one has the finances to pay the bills in this type of situation."

The disability benefits that now cover his rent, food and daily expenses could have yielded more, but he never increased the policy. "I distinctly remember six months before this all happened to me, the insurance company calling me when I was busy with a patient," he recalled. "It was time to upgrade the policy if I wanted to increase the coverage. I was so busy, but I remember just as plain as day telling the secretary, 'I don't have time for that now.' And I didn't [ever upgrade the policy]. I could kick myself, but I can't do anything about it now. But I'm fed, I'm warm, and I'm not on the street."

Dr. Bramen said he also has good health insurance that covers his medical expenses 100 percent. His policy has an annual \$1,500 deductible and costs about \$3,600 in premiums and other out-of-pocket costs, but so far this year it has picked up the \$100,000 in medical bills he has incurred since May.

"Doctors seem to order things without realizing how much they cost," he said. His IV nutrition treatments run \$15,000 a month, and he administers them himself. The oral medications cost another \$900 a month. "If I didn't have good insurance or [I] had insurance that capped expenses, I'd be up the creek

without a paddle," he noted. Ironically, he added, when he applied for both health and life insurance several years before his diagnosis, he told the insurance agent about contracting hepatitis from a needle stick. Today, that same disclosure could result in his being uninsurable.

### They're afraid to get the test

Dr. Bramen does not advocate mandatory HIV testing of health care workers but advises all physicians to be tested anonymously. "The doctor is in more danger of being infected than the patients are," he said. "That's not just the party line; it's fact."

HIV-positive surgeons or physicians who perform invasive procedures should "adjust" their practices, Dr. Bramen said. "That doesn't mean [physicians] have to leave practice, but they may have to go into another field, because there is that chance [of transmitting the virus]. I know surgeons personally who have discussed this with me and are scared to death of going to get a test. But it's better to know than not to know, because then you can do something about it."

### Don't look on the dark side

Looking into the future, Dr. Bramen tempers reality with a positive attitude. He also relies on his faith for strength. "I

try not to look toward what could happen," he said. "You try to keep a positive attitude that some type of medication is going to come along that will prolong your life. But then you also have to be realistic. So far, nobody has lived through this. Eventually it gets you."

"So you have to keep a positive attitude," he continued. "Every day that you feel good is another day that you have to do whatever you can do that day. You try not to look at the dark side of it, but

it does keep cropping up. I have days when I just feel so down and then other days that I feel pretty good. It's a battle."

*\*Editor's note: "Dr. Jonathon Bramen" is a pseudonym used to protect the confidentiality of the physician who agreed to share his story with Illinois Medicine readers. The physician has requested anonymity because of the possibility of unfounded liability lawsuits. According to the U.S. Centers for Disease Control and Prevention guidelines and the physician's knowledge of the disease and his medical practice, Dr. Bramen is confident he posed no risk of transmitting the virus to any of his patients.*

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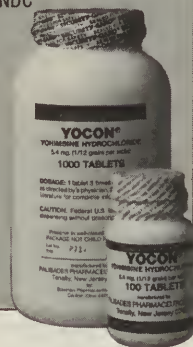
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#### References:

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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## Tobacco bills on hold

(Continued from page 4)

nance, selling cigarettes had become "not worth the effort."

**ORGANIZED MEDICINE CONTINUES** its press to curb the use of tobacco products. The Illinois State Medical Society House of Delegates has placed ongoing emphasis on the need to ban smoking in open and closed stadia. In 1991, the House of Delegates adopted a resolution directing ISMS to take specific steps toward such prohibition, including contacting the management of Illinois stadiums to encourage them to prohibit smoking at all events and requesting that the American Medical Association encourage other medical societies to undertake similar initiatives.

ISMS will be working with the American Cancer Society, Illinois Division, and Illinois policymakers to ban smoking in stadia.

In other areas, the AMA recently endorsed a ban on smoking on all international airline flights. According to its *This Week* publication, the AMA urged the U.S. delegation to the International Civil Aviation Organization to ban smoking on international flights by 1994.

The AMA also supports legislation introduced by Sen. Tom Harkin (D-Iowa) reducing tax deductions for expenses for advertising or promoting tobacco products to 80 percent, creating new revenues for state health agencies for anti-tobacco campaigns. ■

## Teen health education

(Continued from page 1)

and risk taking, and teenagers are particularly vulnerable because their attitude is one of invincibility," said Dr. Fesco.

In Illinois, 127 teens are infected with HIV, and 32 have full-blown AIDS. In addition, it is estimated that a majority of the 2,450 HIV-infected 20-to-29-year-olds were probably infected as teenagers.

To help physicians in their presentations, ISMS produced a 23-minute videotape, "AIDS: Choose To Be Safe," featuring interviews with teenagers and two ISMS physicians. In addition, an ISMS brochure, "You Can't Be Too Careful: Facts for Teens About AIDS," is available for all groups. The Society has also produced a Spanish translation of the brochure.

Today more than 215 physicians, representing 48 Illinois counties, are members of the volunteer speakers bureau. Since the program's inception, more than 500,000 English AIDS brochures and 100,000 Spanish brochures have been distributed, and 350 AIDS videotapes are currently on loan to Illinois schools and teen groups. Physicians have completed more than 500 speaking engagements since the program began.

Teens engage in all sorts of unhealthy activities, with little knowledge of the effect on their bodies or the dangerous consequences, Dr. Fesco said. "As the number of AIDS cases in Illinois continues to rise, it is more important than ever to continue AIDS education. Physicians must take an active role in this educational effort. It is a matter of life or death," he told *Illinois Medicine*. ■

## Deere

(Continued from page 3)

Center's 77-member "specialty care physician" list. "Physicians must understand that a concept such as the health center is just one of the things we will be seeing in the next decade that will change the way we practice medicine. Concepts such as managed care are bound to become more prevalent."

Dr. Snodgrass said Deere & Co. is well-known as a manufacturer of quality farm equipment and is "continually emphasizing that it will provide quality care to its employees and retirees." He also noted the company's consultation

with area specialists in setting up the health center. "Deere is emphasizing using specialists from our local community, and the clinic organizers have already been consulting with some of these physicians with respect to operational and equipment concepts prior to opening for patient care," he said.

"I have every reason to believe that the family health center will be a quality operation in the way the clinic is organized and that patients will receive quality medical care," Dr. Snodgrass explained. "Going hand-in-hand with the provision of quality of care is an implied element of trust between the employees and Deere. The employees

and retirees have worked for Deere for a long time, and they trust that the company will give them the quality care it is promising."

Dr. Snodgrass said he hopes the new family physicians employed by Deere to staff the health center will join and become active in the Rock Island County Medical Society. Richard L. Bartsh, M.D., the Family Health Center medical director, is already a member, he said.

"It's going to be a team effort between the clinic primary care doctors and area physician specialists to deliver quality care," Dr. Snodgrass noted. "From everything I can see, Deere is doing all it can to make that a reality." ■

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## U. of C. Hospitals

(Continued from page 1)

tals, alleging it was responsible for her care under the Consolidated Omnibus Budget Reconciliation Act of 1985, even though she never entered the hospital.

The U.S. District Court dismissed the case, but the appeals court decision gave the family the green light to file a civil suit. The hospital has asked the court to reconsider its decision, backed by an *amicus curiae* brief filed jointly by the American Hospital Association, the Illinois Hospital Association, the Metropolitan Chicago Healthcare Coun-

cil, Northwestern Memorial Hospital and Illinois Masonic Medical Center.

What is at issue, explained a U. of C. spokesperson, is whether COBRA statutes apply in a pre-hospital setting.

"The worst thing that could ever happen happened in this case," said Susan Phillips, vice president of government and public affairs for the University of Chicago Hospitals. "It speaks to the extreme shortage of pediatric intensive care beds in Chicago."

Phillips added that it could mean that if Nelson's family pursues and wins a suit, hospitals are responsible for every emergency radio call they must direct elsewhere.

**COBRA STATUTES REQUIRE** that whenever a person comes to an emergency room, the hospital is obligated to determine whether the case is an emergency medical condition that is life-threatening, explained Mark Deaton, vice president and general counsel for the Illinois Hospital Association.

"If a hospital determines the case is an emergency," he said, "it also has the obligation to provide the necessary treatment within its capabilities."

"COBRA also governs when and how patients are transferred to another facility if they aren't stable," he added. "The attending physician has to determine whether his hospital is capable of providing necessary care for the patient, or whether it would be in the patient's best

interest to be sent to another facility. In the meantime, the hospital must do everything within its capabilities to treat the patient."

COBRA law applies to all Medicare participant facilities, which means that virtually every hospital in the nation is governed by its statutes. The provisions were developed to help curb patient dumping, said Deaton.

"In this case, the patient never came to the hospital," Deaton said. "The hospital had no opportunity to evaluate or treat in accordance with COBRA. The bottom line is that the hospital's obligations should only be triggered when a patient actually enters the facility. We feel the judge is stretching COBRA way beyond its original intent." ■

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## Insurance plan

(Continued from page 1)

(800) 458-5736, or write the AMA Insurance Agency at 200 N. LaSalle St., Suite 400, Chicago, Ill. 60601.

**NONPHYSICIAN HEALTH CARE** workers have access to a similar plan. A Boston insurance company announced it is offering a single policy that covers the entire technical staff of a hospital or health care facility against HIV infection.

The coverage is designed to enhance an overall benefits/malpractice insurance package, according to an Oct. 22 press release issued by Lexington Insurance Co.

If a covered employee insured by the hospital or facility is diagnosed HIV-

positive, the policy pays a lump sum up to \$500,000. Limits are chosen by the facility and may allow different lump sums for separate job categories.

There is no pretesting of any employee or testing at the time of medical incident, the press release said. Also, the policy contains neither a job reassignment or retirement clause. Exclusions cover prior positive tests, self-infliction and unlawful drug use.

"To our knowledge, we are the first major U.S. excess and surplus carrier to offer a product that provides lump sum payments to employees of a health care facility who are diagnosed with HIV infection," said Kevin H. Kelley, Lexington president. ■

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PAGE 12

# Illinois Medicine

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EXPAND HOME  
TB TREATMENT,  
FOCUS ON  
PREVENTION**

PAGE 16

## Fiscal constraints influence first health care task force meeting

**TASK FORCE:** Charged with recommending whether to continue the Medicaid assessment program, the governor's Health Care Reform Task Force met Nov. 30. By Tamara Strom

[ CHICAGO ] Under the gun of a Feb. 1 deadline, Gov. Jim Edgar's Health Care Reform Task Force spent the lion's share of its first meeting hearing how the state's gloomy financial picture and a "no new taxes" pledge will color any decisions it makes.

During the three-hour meeting, the 36-member task force, which includes representatives from medicine, business, hospitals, long-term care, insurance and the legislature, reviewed its charge to recommend funding sources for the Medicaid program. Task force members also heard in great detail that if the assessment program is allowed to expire on July 1, 1993, the state stands to lose \$735 million in federal funding for the state's public aid program. In fact, the assessment program is the source of more income than either the lottery or public utility

(Continued on page 22)

## INSIDE



**What does 1993  
hold for Illinois  
physicians?**

*Use the post card at  
page 17 to send us your  
prediction of what the  
future will be for  
Illinois doctors and  
their patients.*

**IHA, Cost  
Containment Coun-  
cil reach accord on  
data reports**

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**Guess the Santas!**

PAGE 8

## DEPARTMENTS

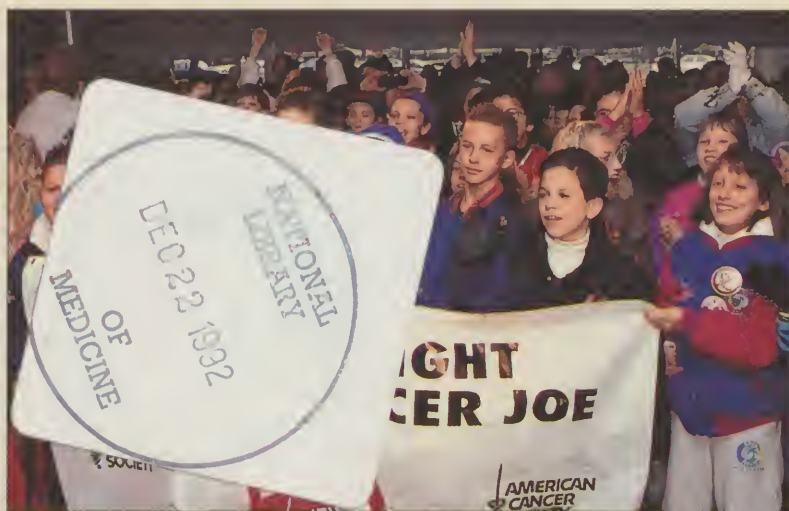
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**ONE THOUSAND** children surrounded the camel pen at Chicago's Lincoln Park Zoo Nov. 19 to observe the American Cancer Society's Great American Smokeout. The fifth graders rallied against Joe Camel while learning about real camels.



M. CANDEE STUDIOS

## Illinois law mandating blood lead testing for children to take effect January 1

**LEAD:** Physicians must soon provide proof of blood lead level testing for children between 6 months and 6 years of age who enter a day care center, preschool or school. By Stacie Crozier

[ SPRINGFIELD ] A new Illinois law that takes effect Jan. 1, 1993, will need the cooperation of physicians and parents to defuse the time bomb of childhood lead poisoning.

Phase-in legislation on lead testing began last January, requiring Illinois physicians to perform risk assessments of all children between 6 months and 6 years of age. After Jan. 1, 1993, all children entering a day care center, nursery school, preschool or kindergarten must provide proof of a blood lead level test. Physicians should indicate completion of the test by

noting it on child health forms.

The Illinois Department of Public Health has set the acceptable blood lead level at 10 micrograms per deciliter (µg/dL) of whole blood - bringing the state's limit in line with the new standard recognized by the U.S. Centers for Disease Control and Prevention. The limit was previously 25 µg/dL.

"The new levels recommended by IDPH show a more realistic standard in terms of clinical manifestations of lead poison-

ing," said Gerald F. Staub, M.D., past president of the Illinois chapter of the American Academy of Pediatrics.

"The whole matter of lead poisoning has been understated for some time," said Dr. Staub, of Rockford. "Low lead levels that were thought to be safe have been found, through research, not to be safe after all. Lead poisoning can cause subtle but serious health problems like learning disabilities and neuro-

(Continued on page 15)

## ISMS PERSPECTIVE

## SHARING CARD OFFERS A CHANCE TO HELP MEDICAL SCHOOLS

Each year the December issue of *Pulse*, the newsletter of the Illinois State Medical Society Auxiliary, publishes a front page with no news, no photographs and no headlines. Instead, page 1 features a roster of contributors, physicians and spouses, whose annual generosity to the AMA-ERF Holiday Sharing Card helps make a \$5 million a year difference to medical schools and medical students in the United States.

"The Holiday Sharing Card is just one fundraising mechanism the state auxiliary sponsors to generate donations to the American Medical Association's Education and Research Foundation (AMA-ERF)," the Auxiliary's AMA-ERF Chairperson Bonnie Ruecker told *Illinois Medicine*. "And the donations noted in *Pulse* are just those from the various boards and Society and Auxiliary leadership. The

(Continued on page 21)



**Jere E. Freidheim,  
M.D., Chairman  
ISMS Board of  
Trustees**

"In 1993, Illinois physicians will be faced with elected officials' attempts to control health care costs, while protecting quality. As board chairman, I have the job of making sure that Illinois physicians are a forceful and informed



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**William J. Marshall, M.D.**  
**Chairman, ISMS**  
**Governmental Affairs**  
**Council**

"Policymakers must consider the 37 million people uninsured and their need for coverage. The real issue, however, is how the state can provide quality care for every Illinois resident and control costs without breaking the budget. In 1993, the legislature could and should consider insurance market reform, medical professional liability reform and targeted cost-containment efforts."



## Illinois delegates play active roles in AMA interim meeting

[ NASHVILLE, TENN. ] Illinois delegates played critical roles in deliberations at the American Medical Association's interim meeting in Nashville, Tenn., in early December. James H. Andersen, M.D., of Oak Brook, chaired the reference committee that recommended the AMA maintain its ethical stance against inappropriate self-referral by physicians. The AMA House of Delegates agreed with the recommendation.

Health care reform competed with self-referral as the most hotly debated issue. P. John Seward, M.D., of Rockford, an AMA trustee, spoke for the AMA Board of Trustees when he called for the profession's unity on health care reform. As a result of reports written by the Technical Advisory Committee on Health System Reform, chaired by Dr. Seward, the AMA supports the creation of a national health advisory body that will form a public-private partnership with the AMA to formulate policy and implement activities in all areas of health policy. In a significant show of support, the house empowered the board to act on behalf of the association and of all physicians to negotiate and actively promote elements of health system reform that it believes best represent the interests of patients and the profession. Finally, the AMA supports cost controls that do not imperil the health of Americans, a move emphasizing the AMA's objections to global budgeting.

Jere E. Freidheim, M.D., of Chicago, chairman of the Illinois State Medical Society's Board of Trustees, served on a reference committee that reviewed the AMA's 1993 \$209 million budget. The committee also considered a resolution urging the AMA not to accept financial support from tobacco companies, a resolution referred to the board.

Joseph B. Perez, M.D., of Rockford, was elected ISMS delegation chairman, and Dr. Andersen was elected vice chairman. Alfred J. Clementi, M.D., of Arlington Heights, completed his two-year term as delegation chairman and Henrietta Herbolsheimer, M.D., and Audley F. Connor Jr., M.D., both of Chicago, were honored for their years of service to the delegation, as was Fred Z. White, M.D., of Peoria. All are retiring from the delegation. Dr. Seward will complete his first three-year term as an AMA trustee in June 1993, when he will seek re-election. He is unanimously supported by the ISMS AMA delegation and the ISMS Board of Trustees.

## CIMRO wins IDPA UR contract

[ SPRINGFIELD ] At press time, *Illinois Medicine* learned that the Illinois Department of Public Aid has awarded Central Illinois Medical Review Organization (CIMRO) a six-month contract effective Jan. 1, 1992, for a new utilization review program. Details will be included in the Jan. 15 issue.

## JCAHO puts three Chicago-area hospitals on probation

[ CHICAGO ] Three hospitals in the Chicago area have received conditional accreditation and have been placed on probation for violating standards set by the Joint Commission on Accreditation of Healthcare Organizations.

The hospitals are Rush-Presbyterian-St. Luke's Medical Center and Belmont Community Hospital, both in Chicago;

and Madden Mental Health Center, near Maywood.

Conditional accreditation means a hospital did not pass on-site inspections, said a JCAHO spokesperson.

The commission found deficiencies in 19 areas at Madden, including drug use evaluation, nursing care, the monitoring and evaluation of medical staff, and dietary services, said Pat Alvarez, spokesperson for the Illinois Department of Mental Health and Developmental Disabilities.

Most violations at the other two hospitals related to record keeping, and none involved threats to patient care, officials said.

## HIAA calls for insurance industry reform

[ WASHINGTON, D.C. ] Racing to get ahead of the health care reform curve, the Health Insurance Association of America Dec. 3 released a draft proposal endorsing universal health care coverage and outlining revenue sources to pay for the program. HIAA termed its proposal a "radical break from previous policy," one that would require all employers to offer an "essential, continuous package" of health care coverage underwritten by private insurers.

No American would go uninsured under the draft proposal, since the government would pay for the coverage of people below the poverty line, HIAA said. The benefits package, to be defined in part by the government, would emphasize primary and preventive care, and would include catastrophic coverage.

In an effort to eliminate the costs now incurred by the insurance industry due to under-reimbursed or unreimbursed care, the proposal eliminates cost shift-

## It's time to change your Medicare status for 1993

[ CHICAGO ] Physicians who wish to change their participation status as a Medicare Part B provider must act now or retain their current status through 1993. To change from a participating physician to a nonparticipating physician or vice versa, doctors must notify Blue Cross and Blue Shield of Illinois, the state's Medicare Part B carrier, in writing. *All correspondence must be postmarked by Dec. 31.* Exceptions are not allowed; if the carrier is not informed by year-end 1992, physicians will be reimbursed in 1993 according to their 1992 participating or nonparticipating status.

To aid in making this decision, physicians may consult the annual Medicare Part B update letter they should have already received detailing reimbursement amounts and limiting charges for all procedure codes. This year's letter, more comprehensive than previous notices, contains reimbursement listings for all codes, not just selected ones.

Participation status changes should be mailed to Blue Cross and Blue Shield of Illinois, Medicare Part B, Provider Participation Unit, Marion, Ill. 62959.

ing by providers from Medicaid and Medicare recipients to private-pay patients. HIAA said its plan includes other cost-containment features, including "discouraging excessive doctor visits, the unnecessary use of technology and unnecessary hospital or specialist care."

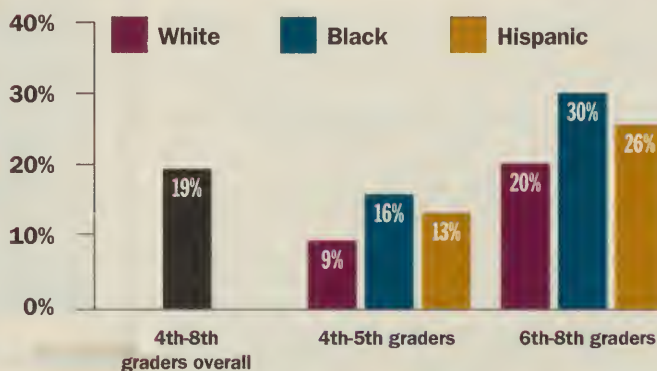
To pay for its program, HIAA recommends eliminating tax breaks on insurance premiums paid for coverage above the basic benefits package. Premiums for the basic coverage would not be considered taxable income.

"This reform proposal marks a fundamental shift by insurers and indicates our deep commitment to meaningful health care reforms that ensure coverage for all Americans while preserving the tradition of high-quality care," said HIAA Board Chairman Ian M. Rolland. "We expect that these measures will lead to universal and more affordable health care for the country. It is also fair to say that it heralds a new era for hospitals, doctors and insurers."

## PHYSICIAN FACTS

### Chicagoland children skipping breakfast

Between Sept. 22 and Oct. 7, 1992, Blue Cross and Blue Shield of Illinois conducted a poll of 1,048 pupils in fourth through sixth grades. The purpose of the study was to gain an overview of a Chicago-area child's typical 24-hour day in terms of health behavior and activities. The results indicated that children who know better slip into poor eating, sleeping and exercise habits, and many skip breakfast.



Source: Study by Blue Cross and Blue Shield of Illinois.

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# Northwestern Memorial Hospital to build \$600 million complex

[ CHICAGO ] Northwestern Memorial Hospital recently announced plans to build a new 526-bed hospital and ambulatory care facility on land currently owned by Northwestern University.

The ambulatory care facility will be a joint venture with the Northwestern Medical Faculty Foundation group practice and will include office and clinical space for about 400 physicians. The hospital will handle more than 26,000 annual patient admissions and, through the NMFF facility, more than 800,000 patient visits.

Total cost of the project, which includes a multistory 2,100-car parking structure, is projected to exceed \$600 million, with the hospital portion projected at about \$580 million. The new hospital and the ambulatory care facility will each hold 1 million square feet.

The site, in Chicago's Streeterville neighborhood east of the city's upscale Michigan Avenue shopping district, is bordered by Huron Street, Erie Street, Fairbanks Court and St. Clair Street. The hospital will purchase the land from the university.

Hospital officials said the complex will include 96 intensive care beds and centers for comprehensive ambulatory surgery, transplantation, clinical research, trauma, sports medicine, clinical cancer, clinical cardiology, neurosciences, blood and orthopedics.

The plans will not impact the 135-bed Prentice Women's Hospital and Maternity Center at 333 E. Superior St., nor the 80-bed Institute of Psychiatry in the Stone Pavilion at 320 E. Huron St. Officials said the project will generate 1,000 construction jobs and be ready for occupancy in 1998. The hospital received a certificate of need for the planning phase and, although they have yet to apply for the construction CON, officials said they are in close communication with the Illinois Health Facilities Planning Board.

Meanwhile, reports that the University of Chicago Hospitals is embarking on a similar project are premature, said a spokesperson. The 659-bed Hyde Park facility on the city's South Side has not yet applied for a certificate of need, he said.

**IN A RELATED DEVELOPMENT,** Cook County Board President Richard J. Phelan's plans for a new county hospital got a boost from a report issued Nov. 23 saying construction of a new facility would be more economical than renovation of the battered 79-year-old Cook County Hospital. The report was written by a committee Phelan appointed to advise him on health care issues.

The committee said, however, the new facility should provide no more than 695 beds, considerably fewer than the current 918-bed hospital. The report justifies the smaller size by estimating that demand on the existing hospital will decrease 10 percent to 15 percent when the county finally opens the shuttered Provident Hospital on Chicago's South Side.

Although estimates to construct a new hospital have ranged from \$300 million

to \$500 million, the committee report said the county would have to spend \$195.7 million over the next 10 years to repair the existing structure. Phelan's proposed 1993 budget includes \$5 million to begin drawing plans for a new hospital, but the county board has yet to officially vote to build it. ■



Gov. Jim Edgar

"I look for 1993 to bring continued improvements in making quality health care accessible to all Illinois citizens. I also hope 1993 will bring a permanent funding mechanism for the Medicaid assessment program so that our health care providers are reimbursed for their time and talents in a more reasonable time frame."



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# REPORT

## FOR *Illinois Physicians*

### UPDATES FROM YOUR MEDICARE B CARRIER

#### New Payment Floors for Electronic and Paper Claims

As a means to further encourage Electronic Media Claims (EMC) submission, Congress recently passed legislation to establish separate payment floors for electronic claims versus paper claims. The floor for paying electronic claims will be 14 days and the floor for paying paper claims will be 27 days, regardless of participation status. In other words, electronic claims will be paid no sooner than the 15th day following receipt and paper claims will be paid no sooner than the 28th day following receipt. The Health Care Financing Administration (HCFA) will implement these floors for Medicare B claims received on or after January 1, 1993. Electronic Funds Transfer (EFT) will also be available in the near future to providers who submit claims electronically.

#### Check Pickup Discontinued

With the publication of the Bureau of Program Operations directive BPO-93-FN on October 21, 1992, HCFA announced its revised payment policy, which includes a direct deposit option for those providers meeting the qualifications for electronic payment as outlined in the notice. This electronic funds transfer (EFT) option will be available to Illinois providers submitting claims electronically very shortly.

The directive also prohibits providers from picking up, requesting next day delivery, or using a courier service for hardcopy checks, except for emergency situations. The effective date published for this provision was November 20, 1992.

However, in the interest of moderating any adverse financial burdens the check delivery provision of this directive may place on Medicare providers, HCFA has extended the effective date of this provision to January 1, 1993.

#### Physician Disclosures Mailed November 20, 1992

On November 20, 1992, the carrier mailed 1993 physician disclosures to all physicians in Illinois. This year, physicians practicing in Option 2 groups will not receive individual disclosures. Rather, the group will receive a disclosure which applies to all physicians within the practice. Option 2 groups are those in which physicians who perform services bill Medicare in the name of the group and have assigned payable benefits to the group. Option 2 groups which have new physicians on staff will receive separate disclosures for these new physicians.

Option 1 groups, that is, groups where physicians bill services in their own names but have assigned payable benefits to the group will receive a separate disclosure for each physician. Solo practitioners and new physicians will also receive separate disclosures.

If you have not received a 1993 physician disclosure by December 1, 1992, please contact the Medicare B Provider Hotline.

(12/18/92)



**Janice D. Schakowsky**  
State Representative  
Evanston



"I think there will be a couple of issues. There will continue to be an effort to move on universal health insurance. This will happen with an eye to Washington, of course, but I think no matter what the Clinton administration does, [the federal government] will leave the states a lot of leeway and will encourage experimentation."

## Physicians support health department for Knox County

**M.D. PUBLIC HEALTH EFFORTS:** Doctors are credited with helping end Knox County's reign as Illinois' second-largest county without a local health department. By Tamara Strom

[ GALESBURG ] The new Knox County Board of Health began setting priorities for community-based public health programs at its first meeting Dec. 2. But the excitement among board members over creating the county's first health department was tempered when they learned money from a new tax increase approved by voters Nov. 3 to fund the project will not be available until June 1994.

In the meantime, the board will concentrate on hiring a full-time administrator and use its share of an Illinois Department of Public Health grant to get the project under way, said board member Carl E. Strauch, M.D., a Galesburg internist. Jefferson County will also share this grant for its new health department, according to IDPH.

"It will take a while until everything is up and running," Dr. Strauch said. "Right now we're assessing what needs the county has and what organizations are already providing services. We want to move the [Women, Infants and Children] program over here so we can use the federal funds in Knox County." Currently, many public health programs in surrounding counties are providing services to Knox County residents.

This reliance on other counties and private organizations helped a coalition of public health advocates build enough political support to pass the tax increase earmarked for the health department. Some in the coalition believe the referendum would not have been successful without the efforts of the members of the Knox County Medical Society. Director of social service at Galesburg Cottage Hospital, Betty Nelson, who spearheaded the health department start-up, credits the medical society's support with "pushing us over the top" on Election Day.

"The medical society's endorsement ran in the local paper, and it helped us tremendously toward the end of the campaign," Nelson told *Illinois Medicine*. "I believe we needed it for local residents to see the medical necessity behind starting a health department. Once the doctors demonstrated their support, I think a lot of patients reflect-

ed that support in their voting patterns, so we owe them a lot. There was a strong push from pediatricians, family practitioners and obstetricians in the community."

One of those physicians was Raoul E. Reinertsen, M.D., a Galesburg Ob-Gyn. Although not all Knox County doctors

supported the tax hike, Dr. Reinertsen spoke in favor of the measure at an Oct. 15 society meeting. After debate, the membership voted to back the initiative. Dr. Reinertsen said much of the opposition was based on misinformation that the "tax would grow and grow without stopping."

"But that is not the case," Dr. Reinertsen said. "And the health department can be run efficiently, save money and

### Tax endorsed for Rock Island health department

**TAX HIKE:** The Rock Island County Medical Society endorsed new taxes tagged specifically for the local health department. By Tamara Strom

[ ROCK ISLAND ] Voters in Rock Island County did the unusual: They voted to raise their taxes. County residents approved a jump in the tax levy from .0221 percent to a maximum of .075 percent to fund immunization programs, prenatal care and other public health programs in the county.

If the local health department continues to lose state funding (this year the agency didn't receive an expected \$10,000), the referendum calls for a five-step process that could culminate in a tax hike approved by the county board, said David Cray, Rock Island County Health Department administrator.

"We didn't ask for the higher levy to spend money wildly," Cray said. "It just gives us a cushion in case we need it. We'd only need to raise money equal to what the state cuts. We want to maintain the level of service" the health department has been providing.

Observers say endorsement of the levy by the Rock Island County Medical Society helped convince voters the new taxes would be money well spent.

"The county health department is losing some funding," said J.H. Gardner, M.D., a family physician and president of the Rock Island County Medical Society. "[The health department] provides a lot of services for the indigent, so [the medical society] wanted to help. We asked residents to vote to raise their taxes, and they did."

Dr. Gardner called the medical society's endorsement a "nice effort" and said he is "glad it passed."

"[Endorsing the taxes] was not really hard to pass through the medical society," he noted. "There were no opposing votes on it."

## Illinois Senate fails to override Gov. Edgar's veto of mammography reimbursement

**MAMMOGRAPHY:** The question of who pays for mammography screening by self-insured local municipalities remains unanswered. By Kevin O'Brien

[ SPRINGFIELD ] Although a year-old bill requires self-insured local municipalities to cover mammography screening to women over 35 whom they insure, it is still up in the air whether the state must reimburse municipalities for the coverage. This funding question represents the broader issue of the state government's mandating that local municipalities provide certain services without state funding.

In 1991, the General Assembly passed the measure, sponsored by Rep. Barbara Flynn Currie (D-Chicago) and vetoed by Gov. Jim Edgar. The legislature overrode the governor's veto.

In the last session, Sen. Joyce Holmberg (D-Rockford) offered legislation (S.B. 1486) exempting Currie's bill from the State Mandates Act, which requires the state to reimburse the local municipalities for the cost of providing the screening. The bill passed, but the governor amendatorially vetoed it, offering language that would have repealed Currie's bill. During the recently concluded fall veto session, the Senate failed to



override the governor's veto.

So now, according to Currie, the requirement that self-insured local municipalities provide the mammography screening to their female insureds still exists, but left unresolved is whether at some

point the "local municipalities will present a bill and whether the state will pay it."

Larry Frang, director of fiscal programs for the Illinois Municipal League, which also opposes state mandates to local municipalities, said the questions persist because no mechanism has existed for the municipalities to apply for reimbursement and the state has never provided it.

Further complicating the problem, he said, is the fact that the State Mandates Act says if reimbursement is not made, the "bill is no longer a mandated bill," and the "issue has never been in the courts." Frang said a mechanism for applying for reimbursement has been devised, but he did not speculate on whether municipalities would take advantage of it.

make health care available to a lot of people. To not support a county health department in my view is not compatible with good medical practice."

With a small tax levy increase of not more than .1 percent of a property owner's equalized assessed valuation, Knox County will "finally enter the 20th century," Nelson said. The levy translates to an annual payment of about \$30 on a \$90,000 house, she explained, adding that she believes the county can put services in place for less than the maximum .1 percent tax.

Without a local health department, the county could not compete for state or federal grants to fund public health programs, she said. In addition, tax dollars were going to neighboring counties to pay for services delivered there to Knox County residents. And budget cuts at the state level forced IDPH to stop providing non-emergency services, such as routine restaurant sanitation inspections, for counties without local health departments. "Ninety-four percent of the state is covered by local health departments," Nelson said. "We were in the 6 percent that wasn't."

In addition to the medical society endorsement, individual physicians donated both time and money to educate patients about the need for a health department. Some doctors donated money to print fliers and posters promoting the project, and others canvassed whole neighborhoods, going door-to-door to distribute literature. Many physicians "lobbied" patients in their offices, Dr. Strauch said.

"Doctors would tell patients, 'Yeah, it will cost you some tax dollars now, but it will save you a lot of money in the long run,'" he said. "I think people bought that."



# IHA, Cost Containment Council reach accord on data reports

**DATA REVIEW:** As a result of a compromise between IHA and the council, the association is dropping its suit against the state agency. By Tamara Strom

[ CHICAGO ] Under terms of an agreement concluded by the Illinois Health Care Cost Containment Council and the Illinois Hospital Association, the council will again publicly release discharge data reports.

A lawsuit filed by IHA in June against the council resulted in a temporary restraining order prohibiting the council from releasing data until the matter was resolved. Now that a compromise has been reached, IHA is in the process of dropping its suit, and the council will revoke its rule blocking IHA from receiving elements of the data for its members.

"Both sides are not completely satisfied, but it is a reasonable compromise," said Council Chairperson Johanna Lund. "The agreement is fair enough to get us out of the courts and get the data moving again. By compromising we are rising to the public good."

Lund said that if the lawsuit had dragged on any longer, it might have jeopardized the "council's reason for being." The goal of releasing hospital discharge data reports is to help consumers and businesses make informed decisions about the health care they purchase, such as preferred provider agreements and managed care, she said.

"We're way ahead of everyone else in the country in collecting and releasing data of this type to help consumers and purchasers contain their health care costs," Lund told *Illinois Medicine*. "But now we have to make sure we keep that edge. It's been five months since we've been able to release any data, but I'm certain we can play catch-up pretty fast."

**THE COUNCIL VOTED UNANIMOUSLY** Nov. 17 to accept the agreement, with IHA and Illinois State Medical Society representatives abstaining. The IHA Board of Trustees ratified the agreement Nov. 19.

Although ISMS supported the need to get the data back into the marketplace, the Society abstained because "our ongoing concerns with IHA and how it's going to use the data have not been resolved," said Robert K. Burger, ISMS vice president for health care finance and representative to the council. "Under terms of this agreement, the council will not provide physician-identified data to any party. However, it is likely that hospitals will, independently of the council, allow these data to be used. Therefore, the Society still harbors reservations about the use of the data to promote economic credentialing."

According to agreement provisions, however, IHA will receive only the Research Oriented Data Set (RODS), which does not include physician identifiers. In addition, the compromise calls for penalties to discourage any breaches in patient confidentiality that might occur from future improper release of the data.

Lund explained that the RODS com-

puter tapes will be available at no charge to IHA to review for accuracy. If the tapes are used for any other purpose,

(Continued on page 18)



**J. Dennis Hastert**  
U.S. Representative  
Batavia

"We need to reform our malpractice laws. Under our current malpractice system, legitimate claims often take years to prove in court, and much of the benefit goes to lawyers, not the victims. We need to cap 'pain and suffering' awards at a reasonable limit and set up alternative dispute resolution mechanisms that promptly pay those truly victimized and eliminate frivolous suits."



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# Illinois Medicine

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E D I

## That was the

It's the time of year for reflection, time to look back over the past year and evaluate the changes in the health care picture in Illinois. For the past few years, *Illinois Medicine* has published something called "Year in Review," a pictorial recap of the year. This year we've turned our focus ahead and asked 13 people, people who should know, what they see in their crystal balls for 1993.

Which is not to say the past year isn't worth a good once-over. We featured the first ISMS Employee of the Month in January. The "Physician First Service" project has been driven all year by the sincere and energetic desire of the board and staff to make ISMIE the best insurance company in Illinois.

HCFA released its final CLIA office lab regs, and they lived up to expectations by contributing further to the hassle factor. If we need a shining example to hold up as an excellent reason not to let the government run health care, CLIA may be it. The Illinois Supreme Court upheld the certificate of merit requirement – an important part of the tort reform measures your medical society accomplished in 1985 and 1987.

The Society moved its annual meeting to Oak Brook, and there delegates adopted 10 principles of health care reform that gave the Society a platform from which to educate the public and evaluate formal proposals put forth by other groups and political candidates. Immediately after the annual meeting

the Chicago River backed up into some of the most expensive basements in Illinois, those of the Chicago Loop.

The General Assembly had the good sense not to pass a universal health bill and ISMS officers and trustees made road trips to newspapers across the state, meeting with editorial boards, publicizing the ten principles and generating positive media highlighting medicine's point of view.

The AMA meeting in June heard impassioned debate on the ethics of self-referral, finally deciding the issue at the Interim Meeting. Illinois' own, John J. "Jack" Ring, M.D., finished his term as AMA president.

In July *Illinois Medicine* got a whole new look and the summer saw a season of campaigning where health care received more attention at the national, state and local levels than it has in the previous several elections. Most politicians on the campaign trail had something to say about health care reform; some of them were more specific than others. The less specific appeared to have won at the national level, as President-elect Clinton works to flesh out the details of his "managed competition" proposal for submission to Congress during the first 100 days of his new administration.

In the fall Gov. Edgar signed a bill exempting physicians from required service as witnesses to legal executions. The policy adopted in April by ISMS delegates was now one step closer to reality,

## PRESIDENT'S LETTER

### The best things in life are felt in the heart

By Arvind K. Goyal, M.D.



*"We are known by what we give to those who cannot give anything back."*

An ear, nose and throat specialist was called into a hospital emergency room in the wee hours of a morning to see a patient he had never seen before. The patient was examined shortly thereafter and diagnosed: peritonsillar abscess. The abscess was drained before the sunrise, appropriate antibiotics and other supportive treatment instituted. Careful follow-up occurred as an inpatient until the fever came down and the patient was able to eat. Then came time for discharge. The good doctor spent considerable time going over follow-up instructions. Included in that discussion were fees for services rendered and offer to do insurance paperwork, if necessary. That upset the patient enough to say something like this, "I always knew you were more interested in my money than my health." The patient was now talking – something he couldn't do when he came in! Further commentary included never-ending accusations of greed and values lost upon physicians. The physician defended his work and talked about the excellent outcome of his care as well as the need to be paid for services rendered.

I heard this story second or third hand at the last House of Delegates meeting of your state medical society. It immediately hurt and the impact has persisted to this date. I can still feel it.

Now, imagine, a contingency fee arrangement as practiced by attorneys in a medical setting. A document would have been signed by the patient or his next of kin before the services were rendered. That would have conferred a third or more of this patient's future earnings to the "life saver," that is if the patient were able to walk, talk and eat again. A small risk of not being paid anything would exist if indeed the patient did not get well.

If this was a court instead of a hospital, the judge would first hear all sides of the argument from the patient when his turn came, his family and other parties available to testify. Once the hearings were complete, a date will then be set for announcement of verdict. The court fee would be deposited and legal bills settled as soon as possible. Finally, the orders will be given to start caring for the patient.

An accountant under similar circumstances would insist on a "retainer" agreement for the next twelve months, just to be available for needed services. Add to that a charge for services by the hour. Such memorandum of understanding would have been developed and signed prior to services being rendered, not before the next working day.

A real estate broker facing a similar situation would ask for a credit check

and approval of loan from the bank before agreeing to work. The patient would anxiously wait in the emergency room for the credit and loan application to get approved before the care could start.

An insurance agent would have a long form filled out and submitted along with the first six months' premium check and arrange to have a paramedic or nurse come in to check blood pressure and collect samples for AIDS, diabetes and drug testing. Once approved for underwriting purposes, the patient would then qualify to receive treatment.

A cab driver would start the meter, and tell his client it will be time and a half of the normal meter charge because of the hour of the night. A \$2 per person charge will be levied for additional family members who came with. If the patient agreed, the "cab" will take off, that is, the examination and operation will follow. If there was disagreement, he'll be asked to get off and ride a public vehicle instead!

Notwithstanding all these possible scenarios, people expect better than that from their physicians. As a matter of fact, when people are sick themselves, they demand the highest quality of care, without delay and with no consideration of costs. Yet the rising health care costs, unavailable and inadequate insurance for some and underfunded government programs are forcing some of our people to fall through the cracks, resulting in waiting as long as they could to get care, sparse, if any, preventive care, and increasing limitation of choices. During my visit to Peoria recently, I treated a 7-month-old infant at Heartland Clinic. Both parents had full-time jobs but no insurance. This clinic, for that family, was God-sent.

During this holiday time let us again remember that medical care including preventive care should continue to remain available to everybody, including our unfortunate and the poor – yet, it cannot be legislated. It must remain voluntary, a matter of one's heart, dedication and duty. Such care will not replace the need for comprehensive and sensible health care reform, yet this mission needs to continue.

Like all other men and women, physicians are entitled to make a living. But, we as a profession, are to be known by what we give to those who cannot give anything back.

As a matter of personal privilege I extend my best wishes to you, your family, and your patients for a joyous holiday season and a healthy and satisfying New Year.



# CRIAL

ear that was

and just in time, as an execution was scheduled for the middle of November. (The prisoner exercised his right to appeal with only hours to spare.)

November was the month of elections. And those elections changed the complexion of the Illinois General Assembly and made significant changes in Washington.

Which brings the cycle of the year around again to December. In Illinois the profession has witnessed a year of change, a year of progress, a year of growth – a year that promises a future even more challenging than the past. In closing, we would like to extend a heartfelt “Thank you!” and cheery “Best wishes of the season!” to – and for – the following:

New babies (We have one, Jack, on the *Illinois Medicine* staff) and old friends. We have lots of those, especially on the *Illinois Medicine* Committee and our advertiser supporters.

A new look (thanks to our managing editor and the firm of Brady and Paul) and a new way of looking at things (thanks to the doctors who responded to our reader survey that focused the redesign). We like to think you like the changes we've made.

Feedback, in the form of letters to the editors, and **back talk**, from the people we ask to read things for us to keep us on track, on time and on the button.

To you all: May your new year be interesting in the best possible ways.



## LETTERS

## PRO defends changes in review process

Since *Illinois Medicine* published an article about PRO review on Oct. 9, 1992, we have received several calls from physicians who believe they have lost the right to appeal an adverse quality of care review decision under the new PRO Scope of Work. I am writing to tell you that is not correct and to add the following information to your article.

During the period you call "bridge" Scope of Work (end of our previous contract with the Health Care Financing Administration on September 30, 1992 – beginning of our new contract on April 1, 1993), Crescent Counties Foundation for Medical Care will reopen a case if the review oversight process has determined the results to be inappropriate. Often this oversight process is initiated by the reviewed physician. Under the Fourth Scope of Work, which begins in April, the right to appeal is maintained and for the first time formally recognized by HCFA.

What has been restricted now is our ability to reopen the same case multiple times. During the past 8 years, in an attempt to be responsive to multiple inquiries and complaints from the reviewed physicians, CCFMC physicians reconsidered decisions, sometimes three or four times. These “safety nets” were built into the review process because the physician board of CCFMC insisted on them. PRO regulation never formally authorized these additional “appeals.” This review process was our own at CCFMC and not common to all PROs around the country.

Similarly, other aspects of our program exceeded the requirements of the law. For example, our use of multiple physicians at each level of committee review; our use of Board certified physicians with specialty matched both to the attending and to the circumstance of care; our use of blinded review for serious cases; and our insistence that all serious cases not only

meet Federal requirements for review, but also stand the test of review by the Quality Peer Review Committee, the Executive Committee and the full Council for Governmental Review Programs (all comprised of practicing physicians), were all procedures above and beyond the Scope of Work. Few states have built similar safeguards to protect physicians. Now, we too are being directed to simply comply with the more limited requirements of the Scope of Work.


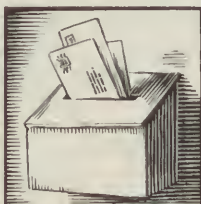
From the onset of this program in 1984, we have believed that certain characteristics were fundamental to PRO review. These included:

- The use of large numbers of practicing physicians – rather than select panels – to conduct review. Review was to be performed by a corps of representative physicians in active practice, not by a handful of “experts.” We believed that this was the essence of peer review, and would insure both equity and the involvement of all physicians.

- The use of multiple levels of review to form a “safety net” for those with potential adverse findings. In other words, we assumed that any individual’s judgment and the review process, itself, were imperfect. Rather than assuming that one specialist and two reviews of a chart could be made “perfect,” we built a flexible system that required many individuals – acting separately – to agree on an adverse decision.

- The use of on-site review. We believed that placing both the nurse coordinator and first physician reviewer in each hospital would maximize communication and interaction, and would increase the sense of accountability of our reviewers.

- The use of subcontractors throughout downstate Illinois to foster greater involvement and sense of ownership by local physicians, and thereby guarantee that a local understanding of standards of practice was included in the review process.



These concepts were implemented and tested at length. In many ways, they came to represent our “philosophy” of review. Many positive outcomes were realized. At the same time, this approach to review has resulted in problems.

- Non-specialists performing on-site review frequently forwarded potential quality issues that were immediately reversed by a specialist. This created a perception of unnecessary hassle.
- On-site review, itself, made it impossible to provide specialty review at an entry level.

- The use of large numbers of specialists, acting independently on their own judgment, very predictably resulted in inconsistencies in the rationale and documentation of review decisions.

- Large numbers of reviewers and multiple review committees made oversight more difficult.

- Multiple appeals resulted in extended time frames for review. This led to physician complaints and CAPs for timeliness from HCFA.

- Our “safety net” review process was itself criticized. Reversals of quality decisions by mid and upper level review committees were not seen favorably as a protection, but rather as evidence of poor review at lower levels.

- The use of subcontractors appears to have delayed, rather than facilitated, the evaluation of a statewide perspective to this statewide program.

In part because our previous approach to review was not perfect, and in part because required changes simply meant that we would now perform PRO review in the same manner as other states; the Foundation sees many potentially positive outcomes from these changes.

- Fewer opportunities to reopen a case may prompt physicians who have received a documentation request to provide detailed information at first contact – not after three levels of review have produced a final determination. Provision of detailed informa-

tion by the attending physician is still the single most frequent reason for reversals.

- Some review committee functions are being assumed by newly appointed Associate Medical Directors. These physicians will bring more immediate oversight to the review process. I expect major improvements in the consistency of review and in our documentation of decisions.

- The use of a smaller number of specialists at a central site will make it possible to use specialists for entry level review, thereby reducing the number of unnecessary documentation requests to physicians.

Beyond these possible improvements, the Fourth Scope of Work includes many positive changes. At least half of our time will now be spent implementing continuous Quality Improvement activities. Data analysis and data sharing for the benefit of all will supplant the nonproductive chart review of a few as our primary focus. While the number of our review committees has been decreased, new physician committees for pattern analysis and special studies are being formed. Physician leadership will guide all of those activities, and we will renew our efforts to provide the highest quality of peer review.

As in the past, the involvement of the Medical Society and all physicians is not only welcomed, but also desired. I thank you for your past assistance, and I encourage you to continue your participation in our activities. Let us all use this very positive opportunity to fulfill the promise of this program, and demonstrate the commitment of every physician to the quality of health care.

– Nasir Ahmad, M.D.  
President  
at Counties Foundation  
for Medical Care,  
Naperville



## Guess the Santa! Who's who in *Illinois Medicine's* first holiday contest?

Who's that in the red hat, hiding behind that fluffy white beard? You know their names – the question is, can you recognize their disguised faces?

Through the wonders of desktop publishing we've "Santa-sized" eight folks who had something to say about health care in the pages of *Illinois Medicine* during 1992. The card opposite this page is your entry form: Just fill in the Santas' real names and mail it in.

Members of the ISMS and ISMIS staffs and their families are not eligible to enter, nor are employees of CCS, our printer, and their families; entries must be postmarked by Dec. 31, 1992, and become the property of *Illinois Medicine*; and in case of more than one entry with the highest number of correct answers (because we don't think *anybody* is going to get them *all* right) a single winner will be drawn at random.

We'll announce the winner and correct answers in the Jan. 15 issue. Here's a hint: Only one of the Santas can sign "M.D." after his name.



**Santa #1**



**Santa #2**



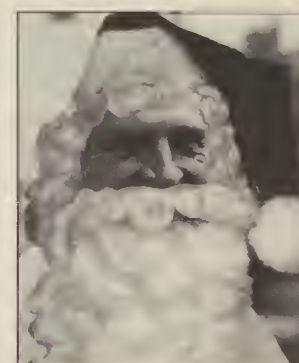
**Santa #3**



**Santa #4**



**Santa #5**



**Santa #6**



**Santa #7**



**Bonus Santa #8**

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MALPRACTICE  
ROUNDUP

PAGE 11

ISMIE  
UpdateExchange Q&A  
PAGE 10

# M.D. helps physicians conquer emotional stress of litigation

**COPING:** When physicians are sued, understanding what to expect may help alleviate some of the stress. By Anna Brown

[ PARK RIDGE ] The psychological changes experienced by physicians sued for malpractice can be as devastating as any traumatic life experience, said Sara C. Charles, M.D., Nov. 18 at Lutheran General Hospital in Park Ridge. Physicians attending the hospital's seventh annual Margaret A. Grant Memorial Lecture learned of the emotional stress to be expected from the malpractice litigation process. Dr. Charles, professor of clinical psychiatry at the University of Illinois at Chicago, has written several books and articles on the subject. A successful defendant in a medical malpractice suit herself, she took the audience through the what's and why's of litigation stress.

"Litigation introduces law into medicine," Dr. Charles told the audience of physicians and other health care providers. "This is adversarial," in contrast to medicine, which is built on trust.

Physicians don't want to think about the possibility of being sued for malpractice, because it's a source of shame. But this denial could result in failure to use preventive measures, such as good communication, especially with peers, Dr. Charles suggested. Other preventive measures include competence and risk management, she said.

**SINCE TORT LAW** is fault-based, Dr. Charles said the only way for patients to be compensated for bad outcomes is to accuse someone. "It's not about competence; it's about compensation," she stressed, noting that the accusation of failure to meet a standard of care is the central psychological event for physicians who are sued.

Loss of control is also a significant stress factor, she



**Sara C. Charles, M.D., told physicians at Lutheran General Hospital that being sued is similar to any stressful life event.**

explained. Although no one can "make it go away," strategies exist to help diminish or buffer the impact of a malpractice lawsuit. Simple remedies such as continuing to work can help physicians regain control and restore equilibrium and self-esteem. Most important, physicians should not take suits personally, Dr. Charles said.

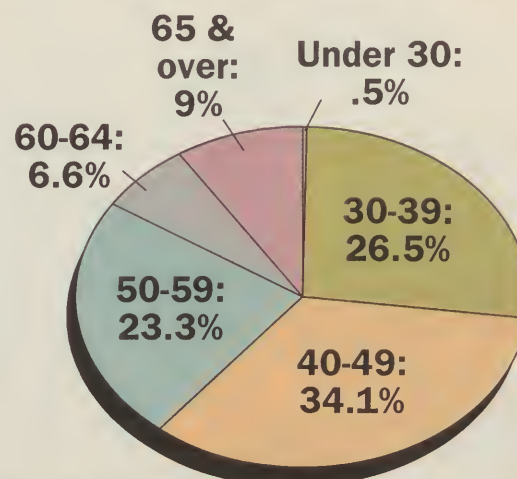
Factors such as the climate of medical practice itself should help physicians realize that they are not necessarily to blame, Dr. Charles explained. "The practice of medicine is inherently stressful. It involves interacting with human beings at the most intimate levels. Patients are stressed and anxious, and regulations and legal intrusions create an environment of heightened stress."

"The litigation environment changes all the time," she continued, listing as an example the new perception of the physician as purveyor of a product, such as breast implants. "This is a legal maneuver, a strategy to get at the 'deep pocket,'" she said. Other products provided by doctors that could be a potential source of liability

include pacemakers, valves and insulin injectors.

**WHETHER PHYSICIANS SUCCUMB** to litigation stress depends largely on the individual's personality. Other factors include the exact nature of the relationship between physician and patient, the event that led to the suit, and even the physician's personal life. Dr. Charles said some of the same characteristics that make good doctors tend to heighten their vulnerability to stress. She described a triad of obsessive-compulsive characteristics that can increase stress: (1) A tendency to self-doubt, which Dr. Charles said is often instilled in medical school; (2) vulnerability to guilt; and (3) a sense of exaggerated responsibility.

## ISMIE policyholders by age\*



\*Active policyholders as of November 1992.

Source: Illinois State Medical Inter-Insurance Exchange.

"When sued, physicians with these characteristics become a plaintiff's attorney's dream," said Dr. Charles.

**NOT ONLY IS EACH PHYSICIAN** vulnerable to stress in a different way, but each lawsuit is also an individual experience, even for physicians who have been sued more than once, Dr. Charles said.

"Being sued is similar to any

stressful life event," such as a divorce or death in the family, she said. Knowing this fact can help physicians anticipate the emotions involved.

"Attorneys and insurers often say, 'Go back to work, forget about it, we'll call you when we need you,'" she said. This can start a cycle of emotional highs and lows — or denial and intru-

(Continued on page 10)

## Risk management seminar series for office staffs still popular

**SEMINAR:** For the third consecutive year, a series on physician office procedures fills its programs to capacity and generates enthusiastic reviews. By Kevin O'Brien

[ CHICAGO ] Building on the success of the last two years, this year's series of risk management seminars for physicians and office staffs continued to be one of the Illinois State Medical Inter-Insurance Exchange's most popular presentations.

"We were totally booked for each of the 27 presentations of 'Documentation: An Essential Office Practice,' and comments from attendees have been terrific," said Jere E. Freidheim, M.D., chairman

of the Exchange's Risk Management Committee.

"I gained a lot on how to handle medical records and charts from the legal standpoint," wrote one participant on an evaluation form.

Still another found value in the speakers' "sharing 'true-life' examples to learn from."

Other participants asked for increased focus on updating legal issues, a point that will be considered when future programs are planned, said Dr. Freidheim.

"Since 1990, the year the series was first offered, more than 5,400 people have taken advantage of this opportunity to learn how to improve procedures in a physician's office," he said.

The seminar is designed to educate medical office staff on the importance of proper documentation and recognition of common problems. Office managers, nurses, receptionists, business managers and other medical office personnel

(Continued on page 11)



OUTLOOK  
'93**Harold L. Jensen, M.D.**  
**Chairman, ISMIE Board**  
**of Governors**

"The Exchange will keep the momentum going in its 'Physician First Service' initiative by reinforcing our strengths: physician ownership and involvement in the Exchange, with board members reaching out to physicians in locations convenient for our policyholder-owners. Defense of our policyholders comes first with us, and we'll continue our excellence in claims handling to satisfy that priority."

**Coping with**  
**litigation stress***(Continued from page 9)*

sion experiences – that can last several years. A physician may try to forget about the suit, but when called for deposition or other legal actions, the same initial feelings return, Dr. Charles explained.

What physicians can expect from the outset of a suit is an immediate emotional reaction, followed by a lengthy legal process that can trigger periodic emotional and physical symptoms. Stress can lead to anxiety and a feeling of lack of

control, Dr. Charles noted. To combat these feelings, she counsels physicians to try to recognize denial and assess the degree of their personal disequilibrium. Monitoring interpersonal relationships is also important, she said, citing a physician who did not tell his wife about his suit until the day of the trial. Another important way physicians can combat stress is by participating actively in their own defense.

Physicians under stress of litigation should also do things that make them feel better, Dr. Charles advised. "Recognize that you are a good person and a good doctor – and have the confidence to defend yourself."

The Illinois State Medical Inter-Insurance Exchange provides help for physicians who have been sued through the Physician Support Group, of which Dr. Charles is a member. The Exchange also sponsors quarterly Physician Support Group seminars for sued physicians, led by group Chairman James P. Ahstrom Jr., M.D. Physicians in the support group have experienced malpractice litigation and are available to talk to physicians in need of support. To receive a defendant information kit that includes a list of physicians in the support group, call the Exchange risk management department at (312) 782-1654 or (800) 782-ISMS. ■



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For more information about reporting to the National Practitioner Data Bank, call the Exchange policyholder relations department at (312) 782-1654 or (800) 782-ISMS.

**Q. Who is eligible for defendant reimbursement coverage?**

A. Defendant reimbursement coverage is available to physicians who attend depositions other than their own or who attend their own trial. The program compensates policyholders \$500 per day for income lost during attendance at depositions or trials. It is intended to encourage and facilitate physicians' involvement in defending their malpractice cases.

Reimbursement is not provided for defendant or respondent-in-discovery depositions in which the insured is named, depositions of the named insured as treating physician but not defendant, scheduled depositions or trials that are canceled, or corporations or partnerships. ■



## MALPRACTICE ROUNDUP

## Who's to blame?

A Service Employees International Union survey conducted by Greenberg-Lake examined what health care means to American voters. Among the questions asked was, "Who do you blame for the rising cost of health care?" The results showed that respondents blame doctors/hospitals and lawyers/lawsuits equally, with each receiving 25 percent of the vote. Other groups blamed were insurance companies (18 percent), patients who abuse services (11 percent), and politicians and bureaucrats (11 percent). The survey included focus groups and a telephone poll of 903 registered voters. ■

## Poor interoffice communication leads to stroke, suit

Prescription of birth control pills to a 45-year-old woman to control heavy vaginal bleeding led to a case that was cited by the Mutual Insurance Co. of Arizona. In its publication *MICA Case Histories*, the company said failure to communicate, systems failure, inadequate history and informed consent issues were problems in the case in which the patient suffered an extensive stroke.

The pills had caused headaches, which she described over the phone to her gynecologist's partner. The partner advised her to stop taking the pills and call the office in the morning, at which time she spoke with a nurse who told her to take one pill daily instead of four. Neither the partner's conversation nor the nurse's was recorded in the chart until several days later. Without knowledge of the previous conversations, the original physician advised the patient to wait three days, then begin taking one pill daily. On the second day the nurse called to see how the patient was doing. Headaches persisted, and the bleeding had increased since she was off the pills. The nurse told her to begin the pills as planned the following day. The physician had no knowledge of the conversation and was never told of the headaches.

After the stroke, the patient was permanently disabled. ■

## Ohio patient receives state's largest single award

*Ohio Medicine* reported that a patient who became paralyzed from a dye injection was awarded \$10.1 million in the state's largest single payout for a medical malpractice case.

The award by the Ohio Court of Appeals increased a trial court award of \$8 million. An additional \$600,000 was awarded to the patient's spouse.

According to *Ohio Medicine*, the defense attorney said physicians should be certain the benefits of serious invasive diagnostic procedures outweigh the risks. ■

## Avoiding consultation liability

*The Letter*, the publication of the Louisiana Mutual Insurance Co., discusses several methods of avoiding liability when primary physicians request consultations.

The physician should talk to the patient about the consultant's competence and the specific reasons for the consultation. Patients should also be told when the consultant will arrive and encouraged to ask questions of the consultant.

The consultant should have complete information about the patient, and the primary physician should not criticize the consultant's opinion in front of the patient.

Other primary physician responsibilities include:

- accurately defining the type of consultation – whether it is a consult only, a consult and treatment recommendation, a consult and treatment, or a consult and assumption of total patient care;
- specifying the problem to the consultant;
- requesting post-consultation discussion with the consultant;
- introducing the consultant to the patient personally, if possible. ■

## Risk management seminars

(Continued from page 9)

are encouraged to attend, and physicians are invited to attend with their staffs.

"Medical office staffs are the physicians' first line of defense in reducing the risk of malpractice claims," said Dr. Freidheim. "They can also be the cause of claims if they become a barrier between physician and patient."

More than 1,800 people – including almost 200 physicians (about twice as many as last year) – attended the 1992 series. Attendees learned how to manage noncompliant patients, document telephone calls and follow up with patients. The importance of maintaining confidentiality and aspects of liability associated with patient relations were also

covered. Each two-hour seminar included a question-and-answer period.

This year's seminar differed slightly in content from those of the previous two years, Dr. Freidheim said, and enrollment in each program was limited to 75 instead of 100, as in past years. "With the smaller audience, we were able to respond more effectively to questions and individual concerns," he added.

Plans are under way for a fourth series next year. Arrangements for individual seminars for larger offices or clinics can be made through the Exchange risk management department at (312) 782-2749 or (800) 782-ISMS. ■



**William J. Rogers**  
Attorney with Bollinger,  
Ruberry & Garvey

"More [malpractice] cases will be filed in 1993 regarding related health care providers, such as nursing homes, HMOs and pharmaceutical companies. Doctors could potentially be involved in these, but as secondary providers. Overall, fewer cases will be filed, and there will continue to be fewer because of informed consent. Doctors have gotten pretty good at giving informed consent, much better than 10 years ago. Litigation has created that awareness."

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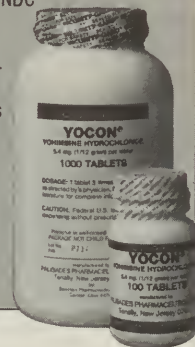
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

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## INDIGENT CARE IN ILLINOIS

# Prescription for the poor



*Caring physicians learn that charity care begins close to home for Illinois' poor and uninsured.*

BY RACHEL BROWN

**T**

hey came to Joliet from as far away as California, Georgia and Virginia, and as close as Springfield, Peoria and Rock Island to attend the first state medical society-sponsored seminar on indigent care.

On Nov. 20, the Illinois State Medical Society brought together more than 150 health care providers and business, community and political leaders to discuss free clinics, referral networks and recruitment of physicians to serve in underserved areas.

"The incredible response to this seminar proves that many diverse groups are willing to work together, listen and learn from each others' experiences, and find solutions to our problems," said Arvind K. Goyal, M.D., ISMS president. "Only by working together can we break the chain of circumstances that often places medical care beyond the reach of the indigent

in Illinois."

The day-long conference featured sessions on the development of free clinics, fundraising, media relations, physician

recruitment, alternatives for indigent care and liability issues. Speakers included representatives from the Will-Grundy Medical Clinic in Joliet, the HealthReach Clinic in Waukegan, the Heartland Community Health Clinic in Peoria and the DuPage Community Clinic in Wheaton.

The conference's keynote speaker, Kevin C. Kelleher, M.D., who helped found one of the country's first indigent care clinics in Virginia's Roanoke Valley, discussed why free clinics are important and why they are a "solution that can work now."

**DR. KELLEHER CITED THREE** important reasons free clinics have been successful and more than 200 have been established in this country. First, he pointed out, they are accessible to the neighborhoods they serve. In addition, free clinics are flexible in structure, because they are developed in response to the communities' particular needs. Finally, because of their extensive use of volunteers, free clinics are inexpensive.

Dr. Kelleher noted that there are two common



**Kevin C. Kelleher, M.D., discusses the importance of free clinics in caring for the poor at the ISMS indigent care seminar Nov. 20.**

MARK GARRETT/PCI



MARK GARRETT/PCI

**Kay Ray, a volunteer and board member of the Will-Grundy Medical Clinic in Joliet, answers questions from seminar attendees during a clinic tour.**



## INDIGENT CARE IN ILLINOIS

objections to free clinics: First, health care planners often feel that widespread volunteerism by physicians, community organizations and businesses is unrealistic.

Through his experience, however, Dr. Kelleher has found physicians to be more than willing to participate in this type of effort. "Caring is at the heart of medicine, and any solution [to the health care crisis] that does not recognize the caring relationship between physicians and patients degrades health care," he said.

Stanley G. Rousonelos, M.D., who helped establish the Will-Grundy Medical Clinic, found physicians in the area very receptive to the free clinic idea. "[Physicians] realize that if they live well because of their profession, they owe it to the community to give something back," he said. Businesses also realize that by supporting these clinics, their image, as well as the image of the community, can be enhanced, Dr. Kelleher added.

**ALTHOUGH SEVERAL CONFERENCE** participants claimed they had encountered difficulty in recruiting volunteer physicians, other attendees suggested ways to encourage physician participation.

"The only person who can recruit a doctor is another doctor," said David L. Gorenz, M.D., a Peoria internist and president of the Heartland Community Clinic. Through his experience in Peoria, he said, he realized that recruitment begins slowly, but once a few physicians agree to participate, "others will follow."

Wendy Richards, M.D., a seminar participant and internist from Chicago, suggested that free-clinic recruiters print literature explaining the clinic's goals and include physicians in the planning stages. "Just like everyone else, our time is important, and we need to know what we are getting ourselves into," she said.

**Fran Burkey (left), coordinator of nursing at the Will-Grundy Medical Clinic, explains the clinic's success. With the help of more than 35 volunteer physicians, 50 volunteer nurses and 120 physicians taking referrals, more than 10,000 patients have been treated since the clinic's opening in March 1988.**



MARK GARRETT/PCI

**THE SECOND COMMON OBJECTION** to free clinics is that they provide inferior care. In reality, Dr. Kelleher said, free clinics are able to provide care not available in a private office by taking advantage of social services, health care agencies and the donated services of hospitals and labs.

"Ninety-five percent of health care needs can be met through outpatient care. By combining this with preventive care and health education, we can provide for the needs of our younger population, who represent the majority of the uninsured," he said.

Despite the popularity and growing numbers of free clinics, Dr. Kelleher acknowledged that supplying health care for the uninsured and underinsured through free clinics is not a long-term solution to the nation's overall health care problems.

"[Free clinics] are a little drop in a big bucket," he said. "They may not be the ultimate answer to our health care needs, but they are a step in the right direction." ■

## Liability risks and the free clinic

For years volunteerism has been extolled as a selfless, gratifying and humbling experience. If that is the case, then why don't more of us do it? In the case of volunteer physicians at free clinics, one reason may be liability.

"With the medical malpractice climate the way it is today, it is no wonder that physicians are reluctant to get involved in charity care and possibly increase their chances of being sued," said Arvind K. Goyal, M.D., Illinois State Medical Society president.

Legislation exists, however, to protect those physicians who feel an ethical responsibility to care for the poor, said attorney Robert J. Baron, during a session at the ISMS Indigent Care Seminar held Nov. 20 in Joliet. Baron, a partner with the law firm Rooks, Pitts and Poust in Joliet, has several years' experience as a defense attorney in medical malpractice cases and currently serves as an attorney for three hospitals.

The Medical Liability Act, signed by former Gov. James R. Thompson in 1990, eliminates the liability of all licensed physicians who volunteer at community-based free clinics, except in cases of "willful or wanton misconduct," Baron said.

Before the bill was signed, only retired physicians could practice in free clinics without fear of being sued.

Baron warned attendees that physicians can still be sued despite this statute. "It is an easy method for a lawyer to at least allege that the doctor is guilty of willful and wanton misconduct," he said. "[I] cannot guarantee that [the physician] wouldn't have to go through the expense and the aggravation of a lawsuit. That's a fact of life."

But Baron offered this consolation: "[I] feel confident that [the doctor] would win the lawsuit. The law is very favorable to doctors. There hasn't been a case holding a physician guilty of willful and wanton misconduct [while working in a free clinic] in the state of Illinois. It is a very tough standard ... and it is very difficult to prove."

Stanley G. Rousonelos, M.D., noted that in the five years the Will-Grundy Medical Clinic has been seeing patients, not one lawsuit has been filed. "[Our patients] are so glad and grateful that we are helping them that I would be shocked if someone [filed a lawsuit]," he said.

The law stipulates, however, that clinics must post a notice in a "conspicuous" place, explaining that the clinic is exempt from civil liability, said Baron. In addition, "the law applies only to licensed doctors who receive no fee from the clinic or any other related institution." ■





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## Cities with lead levels over EPA standards

The U.S. Environmental Protection Agency tested water in 660 water systems, checking homes and buildings most likely to have elevated lead levels in the water supply. Systems with more than 15 parts per billion (ppb) of lead must take steps to eliminate the problem. In that category are the following cities, with the populations, the lead level in parts per billion and percentage of children with high lead levels:

Water supplier	Population	Lead level	Children with high lead levels
Oak Park	54,887	39	*
Decatur	94,081	36	50%
Cicero	61,000	28	*
Evanston	73,233	25	*
Glenview	56,000	25	*
Waukegan	69,392	20	*
East St. Louis	208,976	19	*
Oak Lawn	56,182	18	*
Bloomington	52,000	18	*
Palatine	55,000	17	*

\* not available

Source: Environmental Protection Agency, Environmental Defense Fund

## Blood lead testing law to take effect Jan. 1

(Continued from page 1)

logical disorders that have only recently been recognized."

According to Jonah Deppe, program administrator of IDPH's Lead Poisoning Prevention Program, children with blood lead levels under 10 µg/dL should be retested at their physician's discretion; children with levels of 10 to 14 µg/dL should be retested in six months; and children with levels of 15 to 19 µg/dL should be retested in three months.

**CHILDREN SHOULD BE MONITORED** at regular checkups for possible lead exposure, said Deppe, adding that physicians should ask the following five medical history questions:

1. Does the child live in or regularly visit a house that was built before 1978 and has chipping or peeling paint? (This could include a day care center or preschool, or the home of a babysitter, relative or friend.)
2. Does the child live in or regularly visit a house that was built before 1978 and for which renovation or remodeling is planned or ongoing?
3. Does the child have a sibling, housemate or playmate with confirmed lead poisoning?
4. Does the child live with an adult whose job or hobby involves exposure to lead?
5. Does the child live near an active lead smelter, battery recycling plant or other industry likely to release lead?

If the answer to one or more of these questions is yes, a blood lead level test is then required.

"We estimate that maybe 17 percent of children — about 170,000 children — may have blood lead levels of 10 to 15 µg/dL, and another 20,000 may have a problem serious enough to be in need of medical treatment," said Deppe. "Without mandatory testing, we just aren't testing enough children to find the kids who need help."

"You can find kids with high lead levels whom you never would have suspected," agreed Jay E. Berkelhamer, M.D., a

pediatrician at the University of Chicago.

Dr. Berkelhamer said testing will be simpler for physicians when more labs can process finger sticks rather than

venous punctures. "With a finger stick, physicians can do a blood test for anemia and a lead level test at the same time. If IDPH works with the labs, implementation will be easier."

Protocols for assessing, testing, monitoring and treating children are based on current AAP guidelines. "The AAP's official policy was published in 1987," said Raymond Koteres, director of AAP's Division of Technical Committees in the department of maternal, child and adolescent health. "Physicians should be aware that the AAP's Committee on Environmental Health is in the process of revising the guidelines, but we can't estimate when the revisions will be completed."

**DEPPE NOTED THAT** this year many school districts may be giving parents old child health forms, on which lead screening is

found under "recommended" screens.

"Physicians can note on that form that the testing was done," she said, "but we want them to know that it is mandatory even though old forms won't reflect that."

New forms, she added, will include the lead screen in their "required" section. Those forms may be available by the beginning of the next school year.

Physicians who are interested in using state labs for blood lead level tests may call IDPH at (217) 785-5246.

For more information or to receive a copy of its informational booklet "Guidelines for the Detection and Medical Management of Lead Poisoning for Physicians and Health Care Providers," contact Deppe, IDPH, Division of Family Health, 535 W. Jefferson, Springfield, Ill. 62761; (217) 782-0403. ■



**Joan E. Cummings, M.D.**  
Chairman, Illinois Medicine Committee

"The plight of our many uninsured citizens with restricted access to health care is a moral blight on this country. I believe that in 1993 we'll see progress at the federal level in removing barriers such as ERISA and at the state level, through changes like community rating. These changes will provide relief to these people, many of whom work and contribute to the health of Illinois."



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**John R. Lumpkin, M.D.**  
**Director of the Illinois**  
**Department of Public Health**

"The most important public health issue in 1993 will be to ensure that prevention and health promotion are an integral part of any health care reform. Other high priorities of the state health department are AIDS/HIV education, awareness and control; infant mortality reduction initiatives; and lead poisoning prevention and screening."



## Chicago Department of Health to expand home TB treatment, focus on prevention

**TUBERCULOSIS:** Before TB reaches New York's epidemic proportions, Chicago public health officials move to combat the disease. By Anna Brown

[ CHICAGO ] As tuberculosis rages through New York City, appearing everywhere from hospitals and morgues to factories, Chicago's similar inner-city conditions and homeless population are a target for such devastation. But with forethought and prompt action, Chicago could avoid such an epidemic, said John Kuharik, director of the Chicago Department of Health's TB program.

Kuharik outlined both the city's current efforts to combat the disease and its long-term prevention plans when he spoke at the Midwest AIDS Training and Education Center's presentation "Tuberculosis and HIV: New Challenges for Public Health and Clinical Care" Nov. 19. Speaking at the University of Illinois at Chicago, Kuharik listed major activities, including citywide TB case surveillance, targeted screening and outreach, and increased clinic-based services. The department's TB program is a therapy-based plan that will work in two ways, Kuharik said: rendering active cases inactive and providing preventive therapy to those exposed to TB.

For the first time, CDOH will share grant funds with Cook County Hospital and Cook County Jail to help combat TB, Kuharik announced. "This is a new way of doing business for us, and it's the best way to handle the public's money." The department expects \$300,000 to \$400,000 in grants from the U.S. Centers for Disease Control and Prevention to form a community-based organization to increase home-supervised therapy efforts.

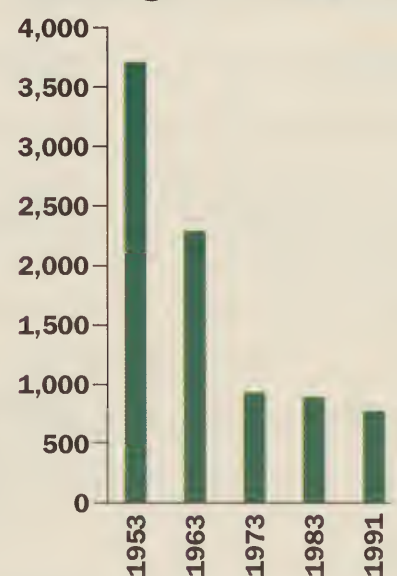
"We've found that you can't control TB working only from nine to five," Kuharik said. Grant funds will be used to hire home therapy workers for both daytime and evening hours.

A MAJOR FOCUS WILL BE faster reporting of TB incidence in the private sector, Kuharik noted. CDOH has identified six Chicago hospitals that have not properly reported active TB cases to the state. Names of those facilities could be announced in the near future if they fail to comply, he said. The department will direct special efforts toward these hospitals to make certain reporting is completed on a timely basis.

Widespread TB testing is also being promoted, but only with proper patient follow-up and treatment. "Everyone agrees that you can't go out of control with testing," Kuharik said. "We have to target our activities." TB screening will be conducted at congregate living centers for HIV patients, STD clinics and HIV testing sites, he said.

For the city's homeless, the department is trying to go beyond CDC recommendations by working with shelter providers to watch for TB symptoms. Although in the winter almost everyone in shelters has a cough and fever, Kuharik said, the worst cases would be sent to isolated rooms to be checked by public health nurses.

### Chicago TB cases



Source: Chicago Department of Health

But he cautioned, "The skin test is [only] the first step in a five-step process. If you do it, you had better be prepared to go through with the whole thing." The other four steps are verifying test results, conducting chest x-rays, providing preventive treatment for those who may have been exposed, and following a full course of treatment for patients with active infection. "If TB treatment is started and not completed, drug-resis-

## IDPH issues fish consumption warnings

[ SPRINGFIELD ] The Illinois Department of Public Health issued new fish consumption warnings for several Illinois lakes and streams due to recent findings of high levels of mercury in the fish.

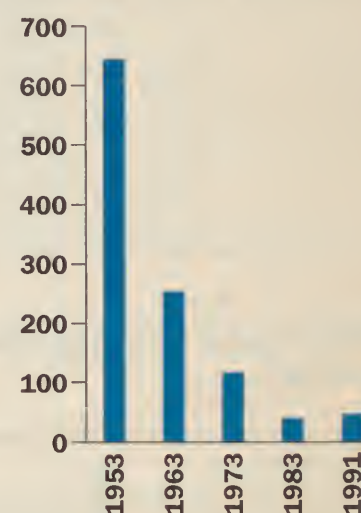
Adults and children are warned against eating bass caught in Cedar Lake and Kinkaid Lake in Jackson County, the lagoon in Chicago's Marquette Park, and portions of the Little

Wabash River drainage basin streams and rivers.

The source of the mercury contamination in these lakes and streams is currently unknown. Other fish species also are being tested for possible mercury contamination.

Eating fish high in mercury has been associated with damage to the nervous system in humans. ■

### Chicago TB deaths



Source: Chicago Department of Health

court to order quarantine for TB patients, the department must prove they have TB and are refusing treatment. That CDOH knows patients have TB but is unable to find them is not a criterion for quarantine. About two to three patients are quarantined each year in Chicago. They are taken to the Cook County Hospital TB ward and are usually cured by receiving home-supervised therapy.

THE MOST COMPREHENSIVE step CDOH has taken to combat TB is the formation of a TB task force of experts and community leaders to focus on the elimination of TB. The group's goals include establishing a network of ambulatory TB care facilities throughout Chicago, creating stronger links between TB clinics and hospitals, and providing critical and extended inpatient care where needed.

"We're going to link this treatment network of inpatient and outpatient care with a new on-line TB data base," Kuharik said. The data base information system will link major city and county TB services, including all CDOH TB facilities and Cook County Hospital, Cook County Jail and suburban health facilities, and possibly the CDC.

Other task force goals include promoting TB research, controlling oversight of local TB efforts, and developing and directing TB prevention programs for high-risk groups, Kuharik said.

Illinois State Medical Society physicians on the task force include its chairman, Whitney W. Addington, M.D.; William Buckingham, M.D.; James Gal-lai, M.D.; Jane Leonardson, M.D.; Petham Muthuswamay, M.D.; Karen Scott, M.D.; and Rebecca Wurtz, M.D. ■

tant TB will result," he said. Mass testing is not recommended for the entire homeless population, he noted, and some shelters contract with hospitals for screening.

Jails, the ports of entry into the state penitentiary system, provide a key point for catching active cases of TB. At Cook County Jail, every inmate receives a chest x-ray, Kuharik said, adding that a case a week is diagnosed on average. There is no time to wait for results of a skin test, since the population shifts around constantly, making it almost impossible to follow up on patients. "We do need to do more to follow [inmates]," he said.

CDOH is stressing integration of TB services for the medically underserved into primary care settings. "Last year, patients had to go to TB clinics for screening," Kuharik said. Although not all primary care facilities have x-rays, only people with active TB are now referred to TB clinics. He listed public TB clinics with full diagnostic treatment facilities in Uptown, Englewood and Lawndale neighborhoods, and at the Fantus Clinic at Cook County Hospital. The Lawndale facility was set to open Dec. 1.

The department's expansion of home-supervised therapy could result in savings of millions of dollars in hospital costs, as well as effective treatment of TB. "TB treatment under the best conditions may take a minimum of six months," Kuharik explained, "but usually at least a year of pill-taking is necessary. It's hard for TB patients to take pills all the time, and they need to be supervised very closely." With home-supervised therapy, a nurse goes to patients' homes to watch them take their medication. Currently 72 Chicago patients receive home-supervised therapy. The department plans to boost this number to 450 within the next year.

"It's a cost-effective program that saved \$1.5 million in one year, eliminating excess hospital days," Kuharik said.

"Quarantine is an absolute last resort" when patients do not comply with treatment, Kuharik concluded. Sometimes monetary incentives are offered to help patients take their medication. For a



## Illinois residents and interns to be notified directly about quality of care problems

**SCOPE OF WORK:** The Illinois PRO has implemented procedures to meet HCFA's requirement to treat residents and interns like other physicians. By Kevin O'Brien

[ CHICAGO ] Residents and house staff members who the Illinois PRO determines may be responsible for a quality-related issue will now be notified about the problem directly, according to the Crescent Counties Foundation for Medical Care. They may, however, ask their hospitals to respond on their behalf.

The change is part of the PRO's transition contract with the U.S. Health Care Financing Administration, a contract designed to bridge the six-month period between the Third Scope of Work and the Fourth Scope of Work, scheduled to begin April 1, 1993.

**DURING THE THIRD SCOPE OF WORK,** HCFA had mandated notifying residents and house staff of quality problems directly, but CCFMC objected because of the difficulty in tracking residents and interns in rotating training programs. The PRO also questioned how an educational intervention could be issued to someone in training.

"The American Medical Association has been adamant on this issue for some time," said John F. Schneider, M.D., an Illinois State Medical Society Third District trustee and consultant to the ISMS Council on Economics. "Since residents and house staff are in training, it is felt that problems with care should be brought to the attention of the head of the training program and that he or she should determine the appropriate action."

**CCFMC SOUGHT CLARIFICATION** from HCFA about its concerns during the Third Scope of Work. In the meantime, the Illinois PRO assigned points and interventions to the resident's or intern's facility. However, HCFA insisted that during the transition period the PRO treat a resident or intern "like any other physician" and implement the direct notification requirement.

Consequently, the CCFMC board approved a proposal for the PRO to immediately notify all hospitals of the change in procedure; encourage facilities to inform their residents and house staff about the possibility of receiving a quality notice, the significance of the notice and the importance of responding; encourage hospitals to advise residents and house staff to share initial letters with the hospital's quality assurance department; and accept a written response from the hospital or discuss the case with the hospital, provided the resident or intern has submitted a signed consent authorizing the hospital to do so. However, it is incumbent on residents to formally request that their faculty respond on their behalf; the PRO will not directly notify the program during the transition period.

Dr. Schneider said it is "highly probable" that in the Fourth Scope of Work HCFA will permit notification of the hospital instead of the resident or house staff member. "The people from

HCFA's regional office have indicated that there have been ongoing discussions along these lines with the AMA about this issue." ■



**Carol Gapsis**  
President, ISMS Auxiliary

"Because ISMS' focus will be on legislation, [the Auxiliaries] will be there to support that. We had a very good year with the campaign coordinators program and the voter registration drive, and we want to be there to help ISMS in any efforts to accomplish medical malpractice reform and caps on noneconomic damages."



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"I believe that the major issues in medicine in 1993 will be health care reform and cost containment. Only after the general outlines take form can we assure that physicians are able to continue to provide quality care for their patients. Other areas of concern will include tort reform, self-referral and physician-hospital relations. Physicians, as defenders of patients, must fight to protect quality medicine and the physician-patient relationship."



LINDA K. HENSON

## MEMBERS IN THE NEWS

Rhoda S. Pomerantz, M.D., of Chicago, has been named clinician of the year by the American Geriatrics Society. Chosen from among 6,000 geriatricians nationwide, she is the first woman to be so honored. Dr. Pomerantz is chief of the section of geriatric medicine at St. Joseph Hospital and Health Care Center in Chicago, and is assistant professor of clinical medicine at Northwestern University Medical School. She lectures on epi-

demiology at the University of Illinois School of Public Health and is past president of the Illinois Geriatrics Society.

At its 61st scientific congress in September, the American Society of Plastic and Reconstructive Surgeons installed Elvin G. Zook, M.D., of Springfield as president-elect. A professor of surgery and chairman of the Division of Plastic Surgery at the Southern Illinois University School of Medicine, Dr. Zook was certified by the American Board of Plastic Surgery in 1972. He is a former chairman of the American Board of Plastic Surgery and is currently a member of the American Association of Plastic Surgeons, American Society of Reconstructive Microsurgery and American College of Surgeons.

David H. Orth, M.D., of Olympia



Fields, has been named medical director of the Lions of Illinois Foundation. The foundation, which provides programs and services to the visually and

hearing impaired, endorsed Dr. Orth for this newly created position at its July 1992 board meeting.

An ophthalmologist, Dr. Orth is a professor of ophthalmology at Rush-Presbyterian-St. Luke's Medical Center and teaches at the University of Illinois' Abraham Lincoln School of Medicine. Dr. Orth is team ophthalmologist for the Chicago White Sox and the Chicago Bulls. ■

## Data reports

(Continued from page 5)

the hospital association must pay for that use, she said. For example, if IHA wants to add the information to its CompData system, it must pay the council, Lund said. The original dispute between IHA and the council began when IHA provided data that showed physician and patient identifiers to competing hospitals through CompData. Under the agreement, individual hospitals retain the right to obtain data they submit.

IHA SAID ITS DATA REVIEW activities help the council improve the accuracy of the data it releases. "We provide [hospitals with] a review of the council's reports to make sure they are accurate," said Steve Scheer, IHA representative to the council. "The agreement allows us to review the data and compare it with the data hospitals send us. Sometimes there are differences between the two, and by utilizing the two sets of data we can catch any errors or inconsistencies that the council would have no way of finding."

Lund said she hopes the next data report will be ready for release in January 1993. ■



  
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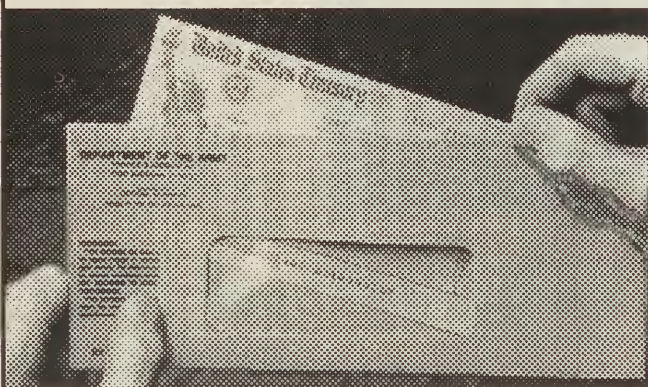
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## Sharing card offers a chance to help med schools

(Continued from page 1)

county auxiliaries also raise funds that are forwarded to the AMA.

"Donors can direct their donations to specific medical schools, and this is part of what gives the card its appeal," Ruecker said. "This year, the first of my two-year commitment as ISMSA's Holiday Card state chairman, I encouraged counties to publicize this fact. For example, medical office staffs can make a donation in the doctor's honor to his or her medical school as a holiday gift. And we do see many checks from physicians noting that their donation is to be directed to the medical schools from which they graduated."

In 1990-91, the last year for which totals are available, the AMA-ERF raised more than \$5 million, almost all of which was turned back to medical schools across the country through a number of funds.

The Medical School Excellence Fund provides unrestricted grants to medical schools. More than \$47 million has been channeled to medical schools since the fund's inception, and the proceeds have been used to support programs for women and minority medical students; to purchase software and equipment; and to fund student activities, research programs and guest lecturers.

The Medical Student Assistance Fund was established in 1983, and contributions have averaged \$500,000 a year since then. The fund provides grants to medical schools for direct financial assistance to students, often in the form of loans. Each medical school's financial program manages the proceeds differently, auxiliary officials noted. The only requirement is that bona fide educational expenses of medical students with recognized need be addressed.

A third fund, the AMA-ERF Development Fund, is used at the discretion of the AMA-ERF's Board of Directors to support pilot and experimental health and medical programs. The board also directs a fourth restricted program, the Categorical Fund, which is used in specific research areas.

The Holiday Card is just one of many fund-raising activities the Auxiliary manages year-round to raise money for medical education and research.

"In 1990-91, physicians and their spouses in Illinois donated almost \$80,000 for the AMA-ERF," Ruecker said. "And medical schools in Illinois received checks for about \$38,000." AMA-ERF donations are presented to Illinois medical school deans at the Auxiliary's annual meeting in April.

"Our annual raffle is another popular fund-raiser," Ruecker said. "We sell raffle tickets all year long and the winners' names are drawn at the annual meeting."

"Next year we're adding a basket auction to our fund-raising activities. The county auxiliaries will prepare creative and imaginative special baskets for a silent auction at the annual meeting, and those proceeds will also go the AMA-ERF."

Looking ahead, Ruecker hopes that next year's Sharing Card campaign in Illinois will be expanded to include hospital administrators, nursing home personnel, medical office staffs and medical supply companies.

"The Sharing Card is a great way to honor doctors and a great way for doc-

tors to help their medical schools. But I don't want people to think that just because the holidays are almost here it's too late - it's never too late to give," she said.

Information about contributions to the AMA-ERF and raffle tickets is available from the Auxiliary office at ISMS headquarters, (312) 782-2099 or (800) 782-ISMS. ■

DENNIS MAGEE



**Charles Downing, M.D.**  
Member of "Partners for Health" speakers bureau  
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### OUTLOOK '93

#### Richard Toptani Medical student

"An issue for medical students and residents will be financing a medical education so that it can be paid back through service or a fixed percentage of income. We need a reasonable way to go into residency and practice that facilitates paying back the loans. Another issue is quotas for primary care physicians. Quotas are wrong; incentives such as favorable financing of the medical education make more sense."



## Health Care Reform Task Force meeting

(Continued from page 1)

ty taxes. Such a loss would leave the Medicaid program in disarray, Illinois Department of Public Aid Director Phil Bradley said.

Although a .6 percent increase in the state's income tax could completely replace the funds generated by the assessment program, task force members were reminded that such tax hikes are not a viable option. "When Gov. Edgar ran for governor, he felt compelled as the election went on to pledge to the voters that he would not increase general income taxes," Bradley said. "Jim Edgar is a man of his word."

"We at the department believe some substitute, replacement or extension [of the assessment program] is necessary to

continue doing what we do," Bradley continued. "If one-third of our funding goes away next July 1, it will throw the health care system in this state into utter chaos."

To illustrate his point, Bradley explained that during the three-hour period the task force met, Illinois Medicaid recipients received about \$500,000 worth of medical care in doctors' offices and hospitals around the state. Half of that amount is reimbursed by the federal government under the assessment plan, he said.

"We spend \$250 million a month on medical services," he said. "[Medicaid recipients] are entitled to those services, and we must pay for them."

Bradley acknowledged that the program yields "no great bonanza" to health care providers. Illinois is 37th in the nation in number of dollars spent per Medicaid client, he said. The program does allow for rate increases to health care institutions, but the rates paid do not cover costs.

In addition, the department is "terribly inadequate in what we pay physicians," Bradley said. Doctors, although not taxed under the assessment program, have been forced to absorb rate cuts of 5 percent. He explained that IDPA does not reimburse providers for their charges, but pays only a percentage of their costs. While hospitals receive about 70 percent of their costs, physicians make do with less than 40 percent, IDPA Deputy Director Theresa Stoica told the task force. This low physician reimbursement is "part of the problem," she said, because it contributes to a drought in available primary care.

**RECOGNIZING THE CONSTRAINTS** under which the task force must deliberate, chairman Ernie Wish, retired managing partner of a consulting firm with health care experience, called for members to "be open-minded" about the "hundreds of ideas" about fixing Medicaid that will likely come before them in the next few weeks. But despite Wish's call for the task force members to remain open to alternatives, the group's discussion showed a wide range of opinions, each reflecting the particular needs of the community or industry the member represents.

For the assessment program to remain

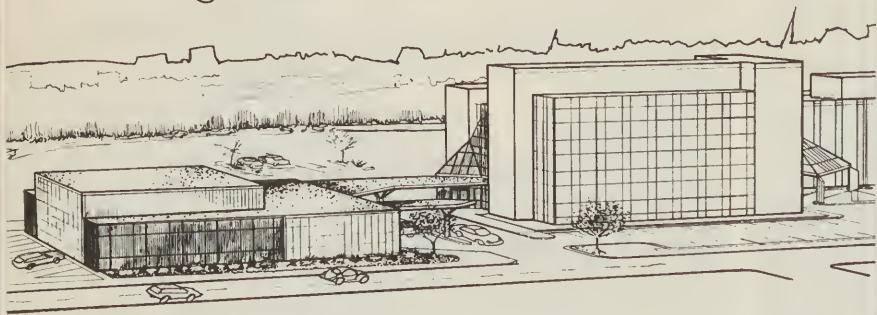
legal, federal regulations require that it be a true redistributive tax plan — no provider paying assessments can be held harmless or be guaranteed to recoup its contribution. This is unpopular among institutions like Edward Hospital, which serves a small Medicaid patient population (2 percent to 3 percent) and therefore does not get back the approximately \$2 million it pays in assessments.

Most of the afternoon's discussions centered on costs and financing of the Medicaid system, but some task force members emphasized the need to include access at the forefront of the deliberations. One task force member noted that the funds created by the program seem to have stemmed the tide of hospital closings Illinois faced in the mid-1980s. "I don't think we can afford to let more hospitals close," said Jerry Wynn, representing Chicago's Winfield Moody Health Center.

Alexander R. Lerner, Illinois State Medical Society executive vice president and task force member, said that as the group struggles to find answers to difficult Medicaid financing problems, it must keep in mind the larger issues of access and quality of care. "Yes, cost is critical, but we must talk about access and quality of care as part of the equation," Lerner said.

Before the task force forwards its recommendations to Edgar Feb. 1, it will hold two public hearings and meet twice more. After the group fulfills its charge regarding the assessment program, it will begin focusing on broader issues of health care reform. ■

## Breaking New Ground in Medical Care



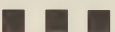
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